PRIVATE SECTOR AND PRIVATISATION IN THE HEALTH CARE SERVICES

A Review Paper for the ICSSR-ICMR Joint Panel on Health - August 1990

Dr. Amar Jesani

with

Saraswathy Anantharam

March 1993

The Foundation for Research in Community Health
84-A, R.G. Thadani Marg, Worli, Bombay 400 018.

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The proposal for research on private sector and privatisation in the health care services was first prepared by our colleague Ravi Duggal. When we started working on this review paper, Ravi continued to take interest in this subject and discussion with him was highly beneficial to us. We are also thankful to Dr. Mukund Uplekar who being a consultant in the private medical practice, provided us with his insight into the working of private sector. The health care economics is not our speciality. As we started identifying issues involved in our subject, we felt at loss due to our superficial understanding of the subject. At this juncture, our meeting with Dr. P.R. Panchmukhi in Pune worked as a moral booster. His encouragement gave us much needed confidence to complete this work.

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BACKGROUND AND OBJECT

The social, economic and political dimensions of health and health care once again became part of the official discourse after the Alma Ata Declaration of 1978. As a consequence, the efforts made by Late J.P. Naik succeeded and the ICMR and the ICSSR established a Joint Panel on Health. A Joint Committee under the chairpersonship of Dr. V. Ramalingaswamy presented to the nation its report "Health for All : An Alternative Strategy" in 1981.

After the completion of a decade since the Alma Ata declaration, the ICMR/ICSSR Joint Panel on health was revived. In order to review achievements of the decade and the implementation of the Joint Committee's recommendations, the Panel commissioned several papers. This paper on "Private Sector and Privatisation in Health Care Services" was one of them. It was discussed at the National Seminar organised by the Panel in Chandigarh in August 1990. After the seminar it was revised and submitted to the Panel in August 1990.

Due to various reasons this review paper (which actually became a monograph) could not be published in 1990. However, the FRCH continued to receive numerous requests for a copy from many individuals and organisations. Some of them were provided with a photocopy. Now, two and a half years after it was prepared, it is being published without any significant change and we hope it will be still useful.

This paper (or the monograph) provides a holistic analytical framework for the understanding of the health care sector. Using historical and comparative methods, it also attempts to formulate some basic elements of the critique of market mechanism in the health care.

The ICMR/ICSSR Joint Committee report more-or-less ignores the private sector and does not provide any alternative strategy to tackle problems created by it. Thus, there was no scope to review its recommendations in this regard. However, this paper strongly argues that, as a short term measure, the private sector must be brought under the ambit of planning and must be stringently regulated. It also demands redistribution of services, removal of financial and social barriers to their utilisation (even in the private sector) and to make equity and social justice goals of the planning. However, given the limitations of service provision through market and the State, greater and increasing direct control in the hands of the organised working people could be the only long-term answer to the problem.

CHAPTER ONE

INTRODUCTION

The private sector and relevance of privatisation policies in the health care services are perhaps the least studied areas in our country. Notwithstanding all statements made in our plan and policy documents, it is evident that in health care, it is not the public sector but the private sector which occupies a predominant place. This is clear from the fact that over 80% of doctors of all systems of medicine taken together and almost 80% of the health care expenditure in our country is accounted for by the private sector. While our policies pre-occupy with the idea of providing a Village Health Guide per 1000 population and how to make them work, our country already has one doctor for 900 people, but a big majority of them are concentrated in the over-served urban areas. It is now amply clear that the policy of turning blind eye to the private health care sector has created a big monster which is eating away a big chunk of our national resources.

The ill-effects of the unrestrained market forces in the private sector are clearly visible. Over-medicalisation, unnecessary surgeries, high cost of medical care and so on have become equally important in India when the vast majority is poor and has no physical access to health care.

It is ironic that given the condition of people in our country, instead of a demand for regulating market mechanism in health care, some pressure for liberalisation and privatisation is building up. In the health care sector at least such pressure is not based on rigorous scientific inquiry. For we know almost nothing about the actual size, investment, efficiency and working of the private health care sector. The private sector is conspicuous by its absence in our plan documents. The privatisation experiments are also not tried out at a smaller scale to understand their relevance. Not only that, certain privatisation methods used in health care, like contracting out in building construction, involvement of private doctors in the disease control programmes, remuneration of doctors through capitation fee etc. have not been studied and their efficacy compared with the public provision of health care.

In such a situation, there could be only two reasons for the increasing pressure for privatisation. First could be the external pressure because privatisation as a major policy issue has emerged in the USA under Ronald Reagan and in the UK under the Margaret Thatcher. Samuel Paul (1988) argues that the "most developing country governments would not have taken privatisation seriously but for the advice and pressure from external forces". The second reason could be ideological because it is easy to play along with the popular belief that public sector health care is inferior to that provided in the private sector.

But it should be recognised that there are serious dangers in hastily copying experiences of the advanced countries. In Chapter Two, after tracing the history of State involvement in health care in India, we have also narrated the history of welfare Statism in the developed countries so that it becomes clear that the issue of privatisation has emerged there in the context of almost universal physical development and availability of health care services. Situation is not such in the underdeveloped countries because the historical issue of physically developing health care services is not resolved. For a country like ours which has experienced a long period of direct colonial domination, it should be "recognised that the actual present of the underdeveloped countries is unlike the past of the developed countries as a result of the intervening history of the latter" (Ranadive K. R., 1984).

Situating the problem of health care development in the historical context is therefore very essential.

In an underdeveloped country like ours the central problem of all discourse must be : **How to make all basic health care services physically accessible to all people without creating financial barriers for their utilization.** Issue of efficiency, quality, quantity etc. must be discussed in relation to this central problem. The attempts at dismantling of the National Health Services (NHS) in the UK or strains on the NHS in Canada do not automatically prove the need to dismantle the rickety govt. health care structure in India.

This report argues that, if seen objectively, the issue of reorganization of health care services in India is brought on our agenda not merely because of the inefficiency and failure of the public sector in providing health care to the needy people, but because despite having over 80% of health care services in the private sector and despite having virtually no regulation over the health care market, the health care has not become accessible to the needy people. In short it is not simply the failure of the State but also the failure of the market. However, from a different angle, the question arises is that : Do we consider an agency controlling 20% (or less) of health care services more responsible or an agency controlling over 80% of health care more responsible, for depriving millions of our people of basic health care services? In essence, the criticism of the State for lacking political will to use its might and force the private sector to be socially more responsible, is qualitatively different from arguing that public sector services should be privatized.

CHAPTER TWO

STATE INTERVENTION IN HEALTH CARE SERVICES

Charles Darwin's "The Origin of Species", first published in 1859, revolutionised our understanding of the evolution of humankind. His study dispelled the myths propagated by the creationist theorists that each species has been independently created by the Creator; and he established that "species have descended from other species" in their struggle for existence and in the process of Natural Selection (Darwin, 1974). In less than two decades after Darwin, Lewis Morgan in his pioneering anthropological work, "Ancient Society" exploded another myth which considered the basic social institutions like the family and the state as unchanging or eternal (Morgan, 1982). Using the information collected by Morgan, in 1884, Frederick Engels argued that the basic social institutions like the family, private property and the State have resulted from the historic development of social division of labour and have undergone profound changes since then (Engels, 1979). The human history, when viewed from the materialist and the rationalist perspective, informs us that the social formations based on private ownership and control of society's resources were preceded by those in which the private property was non-existent and society's resources were communally owned and managed.

Thus, it can be easily postulated that the first ever "privatisation" of society's resources took place when private property made its appearance in the society. The social division of labour and private property divided society into classes and led to the appearance of state as a socio-political entity distinct from the society in general (also called civil society) (Mandel, 1979). **Thus the first social process of "privatisation"** contributed to the emergence of State power which regulates and reproduces the social structure of the society.

The society is not a static organisation, it is always in a state of dynamic progression, steered by the needs of people and conditioned by the outcome of conflicting socio-economic interests. In the process the nature of state power and its function in the society have also undergone profound changes. As we shall see later, in the society today the state plays not only its traditional role of protection and reproduction of social structure, but in order to do so more effectively, also intervenes in the basic socio-economic process. Thus, "not all functions of the superstructure fall within the province of the state" and at the same time, "not all functions of the state are 'purely' super-structural today; nor was this the case in pre-capitalist social formations" (Mandel, 1978: 474-475). The state and the numerous institutions of society which collectively constitute organisation of state, play a very crucial role in the management of the society almost at every level.

Thus, while early "privatisation" in the history of humankind paved the way for emergence and consolidation of the sate as a socio-political institution, the present issue of privatisation, in stark contrast, is raised in the context of the extensive spread of the tentacles of state in the economy as well as services. To be precise, while the early "privatisation" transformed the communal sphere of economy into private property, the privatisation of our times seeks to transform and transfer the state-sphere, thus by implication the public sphere of economy, into the private-sphere.

Therefore, while discussing the issue of privatisation, it must always be kept in mind that it is intimately connected with the existence of state intervention in the economy as well as services.

Some pertinent issues emerge from the above discussion : How has the nature of sate intervention in the health care services changed historically? What are the ways in which the state currently intervenes in the provision of health care services to people? Does privatisation in the present context mean actual reduction of state intervention in the health care services or reorientation of state intervention in explicit and direct favour of the private sector?

In this chapter and in the subsequent chapters we will examine these issues, first beginning with a brief discussion on the history of state intervention in the health care services in India and elsewhere.

STATE INTERVENTION : A BRIEF HISTORICAL ACCOUNT

The research on the ancient and medieval periods in Indian history has come a long way. The European historians first considered India as a land of untold wealth and wise-people, but later, after industrial revolution and Europe's colonial conquests, they described India as a land of stagnant culture, irrational thought and despotic rulers (Thapar, 1966: 15-16). But the rise of national consciousness in the early 20th century produced many Indian historians, who while justifiably criticising the interpretation by the European historians, over-reacted. Their writings reflect unashamed glorification of the ancient Indian past. But their conscious opposition to the European interpretation forced historians to take a fresh look at the sources and helped in beginning a debate (Thapar, 1978: 14). However, despite their significant contribution in the debate, the earlier historians had concentrated more on the history of dynasties than the social formations of that time. It was only in the post-independence period, particularly after the pioneering work done by persons like D. D. Kosambi, that those aspects gained in importance in the historical writings (Thapar, 1978 : 16-17).

In the field of Indian medical history, the attention of historians seems to be more on the Indian systems of medicine, their scientific and technological aspects and their relationship with the Indian philosophies. Although such writing on the Indian medicine have provided some very useful insights into the way medicine was practised, a systematic exploration of medical care provision and the role of state in it, is yet to be undertaken. Let alone the ancient and the medieval periods, even the British period in the modern Indian history, which is otherwise extensively studied, is scantily explored from the point of health care provision under the British rule. To our knowledge, there isn't a single book dealing with this aspect of British period.

Ancient and Medieval Periods : The earliest Indian civilization known to us is the **Indus Urban Culture** of 3000 to 2000 BC. The archaeological evidence show that these cities had well-planned drainage system, almost all houses had bathrooms, many houses had latrines and most houses had wells for water supply. The renowned medical historian Henry Sigerist (1987: 142-3) believed that public health facilities of Mohenjo Daro were superior to those of any other community of the ancient Orient.

During the **Buddha period**, there are evidences to show that the state supported University of Taxila, which among other things, provided medical education to students. Bhikshu Atreya taught there and Jivaka was a product of this Univresity (Mukhopadhyay, 1923: 92 & 94). During the **Ashoka period** (270 BC) the state showed interest in the public works and the provision of medical care. Ashoka founded hospitals all over his empire with medical attendance at state expense (Kosambi, 1970: 160, Kosambi, 1975). The state also undertook planting of medicinal herbs, planting of trees and supply of potable water from wells along the highways. Ashoka also assisted in the establishment of medical centres in the neighbouring countries (Thapar, 1973).

Further evidence on the state's interest in medicine is available from the Chinese pilgrim Hsiuan-tsang who studied at the monastic University of Nalanda, which also provided medical education (7th Century AD). The Nalanda University was supported by the revenue collected from more than 100 villages given to it by the King (Kosambi, 1970: 176-7, Thapar, 1966: 154).

The known text **books of ayurvedic medicine** took many centuries in getting fully compiled. In this process (which also required meeting of scholars and practitioners) the state extended support from time to time. It is suggested that these texts emerged in real fixed form in the first five hundred years AD (Jeffery, 1988: 43). Around the 12th century AD the Muslims brought their own physicians with them and thereby introduced a new system of medicine knows as **Unani**. Jeffery (1988: 46) has suggested that in this period, "successful practitioners were those who served successful rulers and, either through regular service or because of some special healing act were granted an area of land. These

grants may have been supposed to fund specifically medical activities - a dispensary or a small medical school - or they may have been grants to the man and his heirs, even if they ceased practicing medicine." Reddy (1941) has documented medical relief in Medieval South India and noted that both state and religious institutions often subsidised and supported medical care.

There hasn't been serious attempt in our country to document the system of **self-regulation** of physicians and the **state laws** to protect people from the misdeeds of physicians in these periods. Chattopadhyay (1977:21) mentions the reference to ethics in the fourth book on **Sarirasthana** of the **Charaaka-samhita.** Sinha (1983: 266) has argued that "the ayurvedic physicians of ancient India had a well defined medical ethics". But there is almost no evidence on state's special interest in regulating medical practice. In contrast, more is known about the self-regulation in the Greek medicine. It is now well known that Hippocratic Oath was a part of the adoption or initiation rites for new physicians and was a code regards physicians' general duties towards the society (Sigerist, 1934). The Babylonian Code of Hammurabi (300 BC) is the oldest known code of law enacted by the State, which apart from regulating other aspects of social life of the people, also provided for rights and duties of the physician (Sigerist, 1987: 386). Under this Code, "the surgeon was rewarded - or indeed punished - for the results of his efforts, depending on their outcome and the social status of the patient" (Roemer, 1982: 357). There are also other known state laws, such as the Assyrian laws, the Mosaic Code in the Babylonian culture, the Code of Hittites etc. It is important to understand that these codes also expressed the idea that an individual is entitled to compensation for the loss of health caused to him or her by another individual (Sigerist, 1987: 42).

The British Period : In 1764 the East India Company established the Indian Medical Service. European doctors were brought to India to provide medical care to the Company personnel. However, these doctors were not found so useful for treating certain local diseases and thus, the British personnel often sought help of local healers. Jeffery (1988:51) mentions that between years 1814 and 1835 some processes of mutual involvement between local healers and European medicine took place. He says that in 1814 under the instruction of the Court of Directors in London, some attempts were made to investigate the value of local medicines and medical texts. He also mentions that the informal training scheme at Calcutta was established on much more substantial grounds in 1822, as Native Medical Institute (NMI), teaching indigenous and European Medicine. The Muslim Madrassa and the Hindu Sanskrit College (both established with European patronage) had already incorporated some European medicine and anatomy into their courses. However, a change in policy in 1835 abruptly ended this interaction as it was decided to cease teaching ayurveda and unani in those institutions (Jefferey, 1988:51).

After 1857, according to Radhika Ramasubban (1982, also 1985), the main factors which shaped colonial health policy in India were its concern for the troops and the European civil population. The genuine public health measures remained confined to the well planned cantonment areas housing British people. She has also documented that for the general population the sanitary measures were started in ad hoc fashion for pilgrim centres but the realization that they would be very expensive made the colonial government shelve the programme under various pretexts. She also contends that as the era of sanitary reform was superceded by the professionalisation of medicine in England, the colonial government shifted the focus from the sanitary reforms to public health research in India.

In a study by Muraleedharan (1987) of the "Rural Health Care in Madras Presidency : 1919-39", he finds that the colonial state had established dispensaries and hospitals for the people, more in the urban areas but less in the rural areas. In 1924 it introduced a scheme called Subsidized Rural Medical Relief Scheme (SRMRS) which was intended to subsidize private practitioners who agreed to settle down in villages. Such private practitioners were not considered government servants, were required to settle down in the villages specified by the local boards and were asked to treat the "necessitous poor" free of charge. However this scheme was only partially implemented as out of 3000 such institutions planned in 1919, only 1150 were set up by 1935 and their number actually decreased to 1050 in 1938. The reason for such implementation, as formulated by Muraleedharan, was government's reluctance to spend money and in 1930s, the government actually started shifting burden of this rural scheme to the local bodies.

To sum up, despite the lack of sufficient documentation in general and availability of all material written on this subject with us, it is clear from the above narration that during British period, the overall organisation of health care and public health measures by the State largely remained confined to select group of people, namely the British army, the British civilian population and some indigenous elites. It was only in the later period of British rule, also the period of rising nationalist sentiments and movement, that some measures essentially half hearted and ad hoc, were taken to extend State support to health care for the people at large.

Decline of Indigenous Medicine : Scholars have studied the decline of Indian Medicine from various angles. Debiprasad Chattopadhyay first made an attempt in his monumental "Lokayata" (1959) to study ancient Indian philosophy from the materialist point of view. He followed this up by his "Science and Society in Ancient India" (1977) where he came to a conclusion that though the Indian medicine made a transition to rational therapeutics very early in history and showed great promise of scientific development, the changes in the social conditions at that time stifled the growth of its rational kernel. The

entrenched priestly class and its "counterideology" showed "prolonged contempt for medicine and its practitioners in the officially approved social norms" and that was the most serious "external factor" that interferred with the development of Indian medicine. Further, he showed that the law givers at that time insisted that the practice of medicine must remain restricted to those that are supposed to be base born (Chattopadhyay, 1977:6). He also suggested that after prolonged stifling of the development of medical science, a short temporary flourish took place during the Buddha period. But this flourish got extinguished along with the Buddhism losing its earlier fervour. Later on when modern science developed in Western Europe, a tendency during Renaissance period was to look back only at Greek science to understand the roots of it. However, several scholars in their studies pointed out that many fundamental discoveries and inventions made in Central and Western Asia were transmitted to Europe (Bernal 1965, Needham 1966, Crowther 1969:10), which along with Greek science, formed the basis for the modern science to take off in a new social environment. Chattopadhyay (1982:ix) sums this up by saying that "the enormous importance of the contributions of Central and Western Asia to the first foreshadowing of modern science in Europe is now being increasingly realised, though a good deal of more research remains to be done on the subject".

The decline in the importance of indigenous medical practice and its decreasing utilisation by people, seems to be subjects of intense controversies. In his recently published book, Jeffery (1988) has for the purpose of analysis, divided indigenous medicine into "elite medicine" and "folk medicine". His contention is that the elite medicine sought patronage of rulers and the "successful practitioners were those who served successful rulers" (Jeffery, 1982:46). Further, while discussing women's access to medicine, he shows that women were not educated in medicine and the practitioners of elite medicine were not accessible to them due to cultural factors, poverty, high fees, distance and so on (Jeffery, 1982:47-49). Thus in a way he tries to show that these elite practitioners were not accessible to the masses who in fact were forced to rely on folk medicine. After identifying three major factors for the decline, namely, the disunity of indigenous practitioners, the active policy of the State, and the perception by clients that indigenous treatment were less effective than Western alternatives; he concludes that the elite practitioners suffered most through a loss of patronage while the decline of folk medicine is difficult to assess except in terms of general impact of British rule on rural India (Jeffery, 1982:52-53). Gaitonde (1983:146-7) in his study of impact of Portuguese rule on Indian Medicine, documents that in the 16th century, the colonial government had passed an order prohibiting the Indian physicians from practising medicine in Goa. Of course we do not have any evidence of such drastic step by the British Government but some scholars have argued that destruction of traditional village economy which was an inseparable part of the cultural tradition and economic basis of

the practice of medicine, and two centuries of State neglect and other factors contributed heavily in the decline of Indian Medicine (Bannerji, 1985:16). It is of course undisputable that the State neglect led to even decline of some useful preventive practices. For instance, Dharampal (1971) has documented reports of the small pox inoculation in the East Indies. Dr. Holwell (1767) who reported it, also described its miraculous success in preventing small pox. However, in 1804, the inoculation by the traditional method was banned by the Government in favour of modern vaccination (Balasubramanian and Radhika, 1989:42).

Thus it seems that it was simply not neglect and refusal to give patronage by the State, but also State's active actions which deliberately introduced and pushed Western medicine to the detriment of local medical practices contributed in the decline of indigenous medicine.

To Sum up : From the above account it is clear that in the ancient and medieval periods of history, the involvement of State in health care provision was minimal and perhaps episodic; and it took place in context of the State having **direct function** in the economy namely, extraction of surplus from the labouring masses. In this sense, political and economic functions of the State showed greater degree of fusion under the precapitalist order of all variations. At the same time it is also difficult to identify, in the strict meaning of the term, uniform and organised system of **health care provision** at that time.

In the period of modern history, till India became independent in 1947, the question of State intervention in health care was pre-determined and conditioned by the nature of imperialist rule and the internal needs of the colonial government. This also sealed the fate of indigenous medicine, already fairly developed and with great potential; for even in the modern times its rational kernel did not get the historic opportunity to break social fetters. It shows what State intervention and non-intervention (as was the case indeed under the British rule) could do to medical practice, medical care services and even to the science of medicine. No scholarly discourse is needed to show that medicine in the West, which was once even less developed than Indian, could rise to dominant position in the modern times not only due to the changes in the socio-economic condition; but also due to the State progressively accepting its science (howsoever inadequate it was in 18th and 19th centuries) and providing condition for its diffusion. Even after independence, the Indian State failed to provide adequate support to the Indigenous medicine. At the time of independence, the Chopra Committee (1948) report on Indigenous Systems of Medicine made fairly comprehensive recommendations and advocated crucial position for indigenous and "synthesised" medicines in the organisation of health care services. However, the State neglect continued and an historic opportunity to resurrect indigenous medicine was lost (Jesani and Prakash, 1984:34).

While India was languishing under direct foreign rule till 1947, the countries of imperialist power had industrially developed fast and had, under the impact of economic crisis and the pressure of mass movements, gravitated to increasing State intervention in the economy as well as health care. By 1947, the countries of Western Europe had either already embraced or were in the process of embracing welfare statism and economists were distancing themselves from the philosophy of laissez-faire in their theories.

EVOLUTION OF THE WELFARE STATE

Rise of capitalism is associated with the establishment of modern nation States. As nation States were built up and internal feudal restrictions of trade, transit and production activities were done away with; the national economy of modern time emerged and it provided condition for the gradual establishment of what we now know as the systems of health care services.

State Welfare under Early Capitalism : In the 16th and 17th centuries, the European society underwent a change due to decline of feudalism and rise of merchant capitalism (or early capitalism). The merchant capitalism resented feudalistic trade restrictions by the State and thus its pressure aided in the emergence of national economy. But at the same time it needed a strong State to protect its international trade, to conquer colonies, etc. Thus the age of merchant capitalism was also the age of absolute monarchy which transformed the weak feudal monarchy into a centralised State which could rely on its own bureaucracy, army and navy (Rubin, 1979:25). This early capitalism also brought with it increase in poverty, structural unemployment, disintegration of traditional support mechanism due to decline of monasteries etc. Thus, in England the State intervened by passing a Poor Law in 1601, which is also known as Old Poor Law (Miller 1979:120.1). The Old Poor Law combined charity with symptomatic relief; a punishment for being poor with a half promise to provide some work; all in order to purchase an insurance against unrest. The Old Poor Law programmes had combined value systems of feudalism and mercantile capitalism.

We must also keep in mind that this early capitalism went to the lowest possible level to accumulate capital which later financed the industry. Today many feel highly perturbed about the commercialisation of health care. But this early capitalism had even made human beings commodities through its business of slaves. And this was done with an active collusion by the State. When early competitive industrial capitalism of Europe is discussed it should be kept in mind that England emancipated her slaves only in 1832 (Williams, 1966). The USA did it even later, after a bloody civil war in 1862.

State Welfare in the 19th Century : In the second quarter of 19th century England witnessed the slow rise of Benthamite collectivism. Jeremy Bentham's utilitarian philosophy made

distinction between the genuinely indigent pauper and the merely poor independent labourers (Miller, 1979:108). The New Poor Law or the Victorian Poor Law of 1834 was a turning point in the State Welfare , for it was based on the ideology of rising industrial capital in the welfare activity, namely, the charity for the destitute while the able bodied unemployed labourers should compete in the labour market. However, the competitive or laissez-faire capitalism produced its "dead wood", viz. lengthened working hours beyond endurance, shamelessly exploited children and women, destroyed the health of workers and produced miseries (for detailed exposition see Engles, 1975); all of which naturally invited the State to intervene. The idea of "collectivism" gradually gained in currency, especially in the State administration resulting into the progressive State intervention in England (Roberts, 1960). Thus in addition to the Poor Law, factory regulation, education and public health laws etc. came into being. Further, in the last decades of 19th century, Bismark's attempts at welfare through insurance in Germany, created wider interest. Between 1906 and 1914 under liberal ministries, England, too, introduced National Insurance and ushered into what is now known as the **"Social Service State'** (for details see Gilbert, 1966).

Did a perfect liberal or laissez-faire State ever existed anywhere? Winch (1969:21) argues that "laissez-faire has never existed as a conscious system of policy". He feels that a correct way is to make distinction "between measures designed to provide increased protection and security to workers or citizens through collective provision of welfare services; and those measures which have in view the improvement in the overall economic performance of society". According to Dalton (1974:47) what infact happened was that "as the old mercantalist regulations were removed, and with them controls that had been designed for a pre-industrial economy, new controls were imposed for the new industrial economy".

Modern Welfare Statism : In the Western Europe, the transition from the "Social Service State" to the "Welfare State" took place in the second quarter of 20th century. This was a period of the great economic depression, rise of fascism, second world war and the rising combativity of masses. This situation brought about a change in the thinking of economists. Keynes (1967) showed in his book published in 1936 that "the outstanding faults of our economic society in which we live are its failure to provide for full employment and its arbitrary and inequitable distribution of wealth and incomes" and that for the growth of capital, full employment is highly conducive and actually necessary. And further, "the central controls necessary to ensure full employment will of course, involve a large extension of the traditional functions of government" (Keynes, 1967:372-84). The State intervention, therefore, was no longer regarded as an evil, but as "simultaneously a feature of the welfare society as well as a stabilizing device for the economy as a whole" (Winch, 1969:21) (also see Doyal and Pennell, 1981:141-76).

Health care was also taken as a part of the welfare packet, for it is traditionally associated with charity and welfare; and also, under increasing demand and full employment, the productivity of labour power and thus health of workers became important for the economy as such. The working class, on the other hand, had made great sacrifices during the Second World War and after the War got over, flexed its muscles putting unbearable pressure on the governments to go for the National Insurance and complete coverage. The actual implementation, including the relative scope for the operation of private sector in health care, were politically determined depending on the relative strength of the workers and rulers in each country (Navarro, 1978).

What is Welfare State? : Asa Briggs (1966:10-12) provides a very useful definition of welfare State and its distinction from the earlier social service State. Accordingly, a "A Welfare State is a State in which organised power is deliberately used (through politics and administration) in an effort to modify the play of market forces in at least three directions - first by guaranteeing individuals and families a minimum income irrespective of the market value of their work or their property; second by narrowing the extent of insecurity by enabling individuals and families to meet certain 'social contingencies' (for example, sickness, old age and unemployment) which lead otherwise to individual and family crisis; and third by ensuring that all citizens without distinction of status or class are offered the best standards available in relation to a certain agreed range of social services". According to Briggs, the first and second of these objects may be accomplished, in part at least, by what used to be called a 'social service State', a State in which communal resources were employed to abate poverty and to assist those in distress. The third objective, however, goes beyond the aims of a 'social service State' because it brings in the idea of "optimum" rather than the older idea of the "minimum". Thus, as Dr. Desai (1966:163) points out, the welfare State "wants to positively intervene and reshape the economy in such a manner what a floor of social living is created for **all citizens**, by providing a certain range of facilities and provisions irrespective of the status and class position of citizens in society".

This definition makes it amply clear that welfare statism can not exist without the State massively increasing its expenditure for the essential services. This goes well with Dobb's (1978:387) contention that the 1940s is regarded as the period of a qualitative change in the economic functions of the State, a period marked by the State undertaking production, but more importantly, massively increasing its expenditure. Further, in the developed countries, the establishment of welfare States was preceded by four centuries of economic growth aided by intense colonial exploitation and also by over one hundred years of State's minimum services to certain deprived stratas. Thus, when welfare statism was started there, it was essentially a question

of reorganizing the existing services in such a way that the direct play of market forces was consciously restricted or contained at the time of exchange (delivery of services) by the State.

Underdeveloped Countries : For various reasons, the underdeveloped countries were late entrants in the historic process of industrialisation and modernisation. In the developed countries, the State intervention had evolved from the four centuries of economic growth. But the underdeveloped countries had no time to allow for such organic growth of their economies. Further, the economies of most of them even after political independence, continued to remain highly dependent, and even under control, of the developed countries. Thus, their development is highly conditioned by the role played by the State in their economies as well as services. The earliest example is that of Japan, where in the late 19th century and later, the State itself undertook the task of industrialisation. The modern industry was set up by the State at its own expense, and the same was later privatised or transferred to the private sector at the price that the latter could afford. Even the private sector which ultimately took over State enterprises, was nurtured and promoted through State contracts, State encouragement and so on (Mandel 1971:499).

In other underdeveloped countries, too, the efforts at industrialisation are marked by heavy State intervention. In fact the State's role in the establishment and management of the "Mixed Economy" in such countries has inevitably resulted in the expansion and strengthening of the private sector and of the capitalist class. In other words, in the underdeveloped countries the State performs a function of the forceps in delivery, facilitating birth (and later growth) of the capitalist class, whereas in the developed countries the State is used in the way the scalpel is used in surgery, removing regular reappearance of tumours in the economy (Mandel, 1971:501).

INDIAN WELFARE STATE

While examining the welfare functions of the Indian State, the first aspect to catch our attention is the Constitution. V. Jaganadhan (1966:250) says that "India has written into her constitution the ideology of the welfare State". This is very easy to substantiate. The Preamble declares India as "a Sovereign, Socialist, Secular, Democratic Republic" (Constitution, 1977:1). The directive principles of State Policy, lay down in details various functions of the State in various welfare activities, such as, provision of adequate income, employment (right to work), prevention of concentration of wealth, redistribution of wealth, free legal aid, free education, improvement of public health and so on.

In order to help people to effectively exercise their fundamental rights and to progressively realise the directive principles, the

Government of India set up in March 1950 the Planning Commission (1952:3). Thus from the very beginning, planning was made, in Myrdal's (1982:711) words "the intellectual matrix of the entire modernisation ideology". Indeed the planning by the State has become a going concern for the economic development and welfare in the last four decades.

Is India a welfare State? If we apply Asa Briggs' definition we are clearly far away from fulfilling conditions to make claim of having welfare state in our country. The State policies are still talking about providing minimum to selected deprived stratas. This is a far cry from the objective of providing optimum to all. However, the possibility of India evolving as a real welfare State is not discounted by many scholars. For instance, M. Venkatarangaiya (1966:221) believes that in the post second world war epoch, the "States in underdeveloped areas have no other alternative than to function as welfare States", and he argues that, "in western countries economic development took place before the welfare State was born. This was only an accident and it does not follow from it that such a State is out of place in an underdeveloped economy." Although we agree with Venkatarangaiya that even within capitalist economy the ideals of welfare State are worth arguing for and fighting for, we should not, even for a moment, deter from critically evaluating the actual performance of the State in India in making those ideals a reality.

How far have the State policies in India furthered the realisation of ideals of welfare statism in the field of health care? Many scholars have examined State policies and their actual implementation (see Bannerji, 1985, ICMR/ICSSR Committee 1981, Jefferey, 1988 and others). But in brief, it can be stated that what V. Jagannadhan (1966:253) described as three fold policy hazards seem to hold true even today. Jagannadhan formulated these hazards as "(1) The confusing dichotomy between the social objectives of policies and legislation, and the traditional commercial cost benefit analysis of the private market; (2) The frustrating lag between idealism and pragmatism in policy formulation, and (3) The depressing deficiencies in the follow-up of the policies."

Unfortunately in our country, a lot is kept un-stated in the policy documents. Our plan and policy documents on health care, for instance, contain many pious statements and positions on the development of public sector health care, but make only passing reference to the private sector, which in its physical volume, is almost four times bigger than the public sector. Thus mere examination of the stated policies render the analysis fundamentally deficient.

CHAPTER THREE

GROWTH OF PUBLIC AND PRIVATE HEALTH CARE SECTORS IN INDIA

The ICMR/ICSSR Committee Report (1981) concerns itself chiefly with the public sector health care services. Thus it gives little importance to the private sector health care services in its framework of analysis and recommendations. Strictly in this sense, this report, like the plan and policy documents of the Govt. on health care, keeps its position on the private sector unstated.

In order to fill this gap, in this chapter, we have analysed total health care services and within that, presented data on relative growth of public and private sectors, and also on their distribution between rural and urban areas. But the consequences of ignoring private health care sector in plans and policies are starkly manifested in the quality of data available on the private sector.

Quality of Available Data : The ICMR/ICSSR Committee (1981:200) made three important observations on the existing information system : "(i) there are so many useless forms and reports clogging the system that relevant information hardly reaches the point where it can be meaningfully used; (ii) the time lags in data collection and analysis are very large; and (iii) the relationship between the data collected and policy formulation, implementation and evaluation is very tenuous". Its recommendations show that the Committee must have felt highly disgusted with the existing information system. For in a sweeping recommendation it simply said that "All this will have to be changed. A selective process of abolishing most of the present forms and reports is the obvious way to start". The Committee was of the view that the existing information system should be replaced by "a streamlined national information system" and "the local community should be involved in data collection". Few years after the ICMR/ICSSR Committee's report was submitted, a national level information system was introduced to help health care management. Undoubtedly it has improved information system to some extent, though its usefulness at lower levels of health care services where, as the Committee had rightly pointed out, the information "cease to be statistics; they get readily converted into people whom one knows" is highly doubtful. Nevertheless, there is some improvement in the information system for health care management. However, this change is only partial for it is restricted to information on health status and programme-wise target fulfillment by government services. From the information system as it exists today we do not get adequate information on the health care services in its totality.

While collecting and analysing data for this chapter, we faced severe handicap due to limitations of data. Some general comments on the quality and adequacy of available data,

therefore, will not be out of place. **Firstly**, all statistical information on health care services is largely about the public sector health care. Interestingly the size of the private sector health care is impossible to gauge from the existing information. This is true even for information presented in many macro-studies done by scholars, indicating that they must have been as handicapped as we are due to lack of sufficient information on the private sector. What is of more serious concern are our plan documents. Planning without information on the private sector, which is obviously not of insignificant size, can be termed to be only a partial planning. This situation must be remedied at the earliest.

The **second** problem is that we often find gross discrepancy in the figures provided by different government agencies for the same head of information for a given year. This problem is even more acute when we try to compile time-series data. **Third** problem is regarding incomplete information. This is a problem peculiar to the data supplied by the CBHI which annually compiles "Health Statistics of India", perhaps the only official source of comprehensive data on health and health care. Incomplete information in this case appears to be simply due to incomplete or non-reporting by the official agencies like State Governments, State Medical Councils, Medical Colleges and so on.

Fourthly, defining, in an exact manner, each head of information creates many problems because the definition used is normally never stated anywhere. Due to our experience of inter-agency variations in data, which could perhaps be due to the use of different definitions, we always feel uncomfortable when we are required to use definition given by some other agency or by some other document. **Lastly**, just as the private sector is noticed in the data by its absence, the data on health finance, expenditure and investment are noticeable for their poor comprehensiveness.

The usefulness of authentic and comprehensive data on the health care services and their sectoral distribution for the policy makers, for the policy analysts and for understanding policy implementation gaps need not be overemphasized. It should be sufficient to stress here that a rigorous review of grey areas in health care information, the genuine problems of government agencies in collecting comprehensive information with remedial measures needed and lacunae in presentation of data would greatly help policy makers and researchers in their holistic appreciation of the status of health care services in our country.

FACILITIES FOR THE PROVISION OF HEALTH CARE

In order to minimise length of the text and to have focus on the relevant issue, we will be presenting only our analysis of the growth of health care services. The information compiled in tables on which our analysis is based are given in Appendix I.

Further, the analysis on health care provision is divided into (1) The health humanpower and their sectoral distribution; (2) Hospitals and Dispensaries; and (3) Corporatisation of health care.

The Health Humanpower :

The Bhore Committee Report (1946) provides the oldest available data on health humanpower in India. Accordingly there were 47,500 doctors, 1000 dentists, 7000 nurses, 5000 auxilliary nurse midwives, 750 health visitors and 75 pharmacists in our country. The information on the health humanpower from 1952 to 1987 is presented in Table 1 (see Appendix I).

In 1986, the country had totally 7,63,437 **doctors of all systems**, of which allopaths (41.8%) and ayurveds (35.7%) form the bulk (both together constitute 77.5% of total) while the rest are only 22.5% of the total.

There is also a significant increase in the number of paramedical humanpower. The number of **nurses** has increased from 17,989 in 1952 to 2,07,430 in 1986 and that of **nurse midwives** from 51,194 in 1961 to 1,85,240 in 1986. In addition to nurses and nurse midwives, the paramedical personnel who are almost exclusive to the public sector include, 1,08,511 **ANMs** (1987), 88,308 male **MPWs** (1987), 18,819 **female Health Assistants** (1987), and 29,731 **male Health Assistants** (1987). Thus, we have totally 6,38,039 paramedical workers. We need one and a quarter lakh more paramedics to make their number equal to the number of doctors. If the need of paramedics is counted in terms of multiple of number of doctors (and indeed that is how it is traditionally done), the shortfall in paramedics is obviously too great warranting any elaboration.

Rural-Urban Distribution of Health Humanpower : There is a conspicuous maldistribution of health humanpower between the rural and the urban areas; and unfortunately the maldistribution has increased in the last three decades. As no data on rural-urban distribution of health humanpower are presented in publications giving health information, the only source to understand trend in distribution is data presented in 1961, 1971 and 1981 census documents. The same are tabulated in Tables 2 and 3 in Appendix I.

Of the total **doctors** counted in 1961 census, 49.6% were located in the rural areas. This proportion of rural doctors fell to 48.8% in 1971 census and 41.2% in 1981 census, clearly indicating a trend away from the much deprived rural areas, or a kind of **progressive "urbanization" or "de-ruralisation" of doctors.**

Which categories of doctors are responsible for this trend away from rural areas? The data of these three censuses show that the allopathic and ayurvedic doctors have made a turn about in the decade 1971-1981. Between 1961 and 1971, we find an actual

increase in the proportion of rurally located allopaths and ayurveds. However, this proportion sharply falls, so much so that the proportion of rurally located allopaths and ayurveds in 1981 census is even less than that in the 1961 census. In other words the decade 1971-1981 was a turning period in the behaviour of allopathic and ayurvedic doctors regarding their choice of locating medical practise. And their behaviour can change the trend is very obvious from the fact that both categories of doctors constitute a bulk and increasing proportion of total doctors covered in the censuses. Their combined proportion in the total census coverage of doctors increased from 57.1% in 1961 to 69.4% in 1971 to 70.6% in 1981. This is indeed very natural as number of doctors trained in these two systems is very high and today 77.5% of all qualified doctors are from these two systems. The dentists, too, show similar trend in these three censuses as that shown by allopaths and ayurveds. The unani doctors, who were not covered separately in 1961 census, also seem to feel shy of rural areas as the proportion of them rurally located declined from 52.4% in 1971 to 38.8% in 1981.

Only two categories of doctors have some affinity to the rural areas. One of them the homeopaths, are more consistent. For the proportion of them rurally located has progressively increased, initially rapidly when it jumped from 52.4% in 1961 to 61.2% in 1971, but later their rural concentration has slowed down as only 63.7% of them were found rurally located in 1981. Another category showing rural affinity, albeit inconsistently, is that of undefined "All others". The proportion of them rurally located actually dropped from 54.3% in 1961 to 49.6% in 1971. However, this trend got reversed in the next decade with 1981 census showing 59.7% of them being located in the rural areas.

This alarming trend among doctors who increasingly prefer urban areas to set up their practice is not only a serious health policy problem but also a telling comment on the state of rural economy and development of social infrastructure in villages. It shows that market forces are too weak in the rural areas to create any natural environment for doctors to set up their private practice.

As compared to doctors, the paramedical workers are better distributed between rural and urban areas. But this does not mean that majority of them are located in the rural areas. Of the all paramedics covered in 1961 census, 47.5% were located in the rural areas. This proportion showed a sharp decline in the 1971 census as only 39.3% were found to be rurally located. However, the 1981 census data show some improvement in the situation as the proportion of rurally located paramedics increased to 43.1%.

Of all paramedics covered in the census, the nurses show the least affinity to settle in the rural areas. The distribution of nurses was better in 1961 when 38.2% of them were rurally located. This proportion declined sharply in 1971 when only

30.6% of them were found in the rural areas. The 1981 census data show marginal improvement over the 1971 census data as 31.3% of nurses were found in the rural areas. The midwives and the health visitors, on the other hand, showed good affinity to the rural areas. In 1961, 66.4% of them were located in the rural areas. However, since then, their rural proportion has slowly but steadily declined to 65.3% in 1971 and 59.9% in 1981. The "Other Health Workers" also showed decline in their rural proportion from 45.2% in 1961 to 39% in 1971. But fortunately their distribution pattern improved in 1981, indeed a remarkable improvement as 48.1% of them were found rurally located. Since they form the bulk of all paramedics covered in these three censuses (45.7%, 49.6% and 51.6% of total in 1961, 1971 and 1981 censuses respectively), the improvement in their distribution pattern in favour of rural areas has helped improve overall distribution of paramedics in the 1981 census over the 1971 census.

It should be noted here that distribution pattern of paramedics, unlike doctors, is chiefly determined by the distribution pattern of health care institutions where they find employment. In the case of more professionally trained paramedics like nurses and nurse midwives, the distribution pattern is determined by location of hospitals; whereas in the case of auxiliary staff, like MPWs, ANMs etc., the distribution pattern is determined by the number of PHCs, sub-Centers, and dispensaries established by the government.

The census data on health workers have certain severe **limitations.** The categorisation of health workers used by the census does not strictly correspond to the existing categories. In the census data proportion of "other" health workers is very high. Even with the category of "other" health workers, the total number covered in the census is about half the total of health workers in the country. This makes census data less useful to find out actual number of health workers in the country. That is the reason why we have used census data only to understand trends in the distribution pattern of health workers.

We have used below the rural-urban distribution of paramedics found in the census along with some other criteria, to make a rough **estimation of the actual number of paramedics located in the rural and the urban areas.** We must caution, however, that this method of estimation is not so exact and so the findings should be treated with customary reserve. As we noted earlier, we have 6,38,039 paramedical workers in the country. Of these ANMs, male MPWs, female HAs, and male HAs together constitute 38.5% or 2,45,369. Since most of these categories of workers are employed in the public health department, they are likely to be located in the rural areas. Now of the remaining paramedics, 2,07,430, are nurses and 1,85,240 are nurse midwives. If we assume that the rural-urban distribution of nurses and midwives found in 1981 census also holds good for these nurses and midwives, then 31.3% of nurses and 59.9% of midwives are rurally

located. That is, out of 2,07,430 nurses, 64,926; and out 1,85,240 midwives, 1,10,959; might be located in the rural areas. Thus, we have totally 4,21,254 paramedics located in the rural areas. This is 66.02% of the total number of paramedics in the country.

The above estimation, though not so accurate gives an indication that paramedics are better distributed between rural and urban areas, thanks to the establishment of primary health centers and sub-centers in the rural areas by the government.

Public and Private Sector Distribution : There have been a few studies or estimates of the sectoral employment of various professionals including medical humanpower. The Central Bureau of Health Intelligence (CBHI) under the Directorate of Health Services, Government of India, has been publishing data on the number of doctors employed in public sector since 1979. However, the CBHI data for last few years are deficient because some States which account for a significant proportion of public sector employed doctors have not sent their information to the CBHI. Another source for the sectoral employment of doctors is the Director General of Employment and Training (DGE & T), Ministry of labour, which publishes its bi-annual report "Employment Review" on the employment situation in the country. But a major drawback of the DGE & T data on the sectoral employment of doctors is their unreliability due to gross underestimation of the employment figures of doctors in both the sectors. The earliest sectoral employment figures for doctors are available for 1942-43 in the Bhore Committee Report. After that, we could find only one study by the Institute of Applied Manpower Research (IAMR) on the stock of allopaths. This study refers to the DGE & T data on sectoral employment of allopaths in 1964.

Table 4 (in Appendix I) uses the Bhore Committee data for 1942-43 and the IAMR estimates for 1963-64. For the years 1978-79, 1984-85 and 1986-87 the sectoral employment figures are estimated by us using the CBHI data for the corresponding years. This estimation by us is anything but accurate. The estimation was necessitated because in the CBHI data 8 major States - Andhra Pradesh, Bihar, Gujarat, Maharashtra, Madhya Pradesh, West Bengal, Jammu & Kashmir and Tamil Nadu, have not provided their information. Since these States account for higher proportion of total number of doctors in the country, a rough estimation was called for. The estimation was done by taking total number of registered doctors in those States. The proportion of government employed doctors from them was estimated by using a ration of 30% employment in public sector, a considerably higher ratio, as compared to that reported for other States by the CBHI. Selection of 30% as the ratio was in a way arbitrary, but we have preferred to err at the higher side so that public sector employment is not under-represented. The figures thus obtained for these States were added to the total employed in Government. The figures for doctors in the private sector were then

calculated by deducting the number of doctors in Government service from the total number in the country.

There is another drawback in the estimation done by us. The estimation was done by using total number of allopathic doctors registered in the non-reporting States and not by using the number of doctors of all systems. Evidently, the proportion of doctors from other systems, especially ayurvedic, employed in the government rural health care services, is not so insignificant in these non-reporting States. However, this fact could not be accounted for as the CBHI has given no system wise break-up for the reporting States.

The sectoral employment data in Table 4, show an interesting pattern. The Bhore Committee reported 27.4% of doctors in the public sector employment in 1943-43. The IAMR study showed significant increase in the proportion of government doctors to 39.6% in 1963-64. Whereas our estimates show that since then the proportion of government employed doctors has steadily declined in the 1970s and 1980s.

In 1986-87, according to our estimates, 88,105 doctors accounting for 26.6% of total number of allopathic doctors, were in government services. However, when compared with the total number of doctors of all systems (7,63,437), the proportion of government doctor comes to only 11.54%. After accounting for the problems with data and after making allowance for the possible under-estimation, we would not be widely off the mark in suggesting that **only 13 to 15% of all doctors are employed in the government services.**

It is even more difficult to get useful information on the nature of private sector employment of doctors. The IAMR study shows that in 1963-64 totally 60,502 doctors were in the private sector and out of them 53,461 (88.4%) were self-employed and the rest, 7041 (11.4%) were employed in the private health establishments. Thereafter, to our knowledge, no reliable information is available on this aspect of private sector. However, it would not be so unreasonable to suggest that even now the proportion of self-employed doctors in private sector has remained same. Further, given fast increase in the number of non-allopathic doctors and in the absence of any significant increase in the employment opportunity for them, there could be further concentration of doctors in the private practice (self-employed).

Similarly, there is no information available on the rural-urban location of doctors in the private as well as public sectors. But given a substantial decline in the rural location of doctors and also a decline in their proportion working in the government services, one can safely suggest that doctors in the private sector are increasingly locating themselves in the urban areas (may be in small townships and district centres as big cities are fast getting saturated) and the rural employment of government doctors has not increased so much as to make any dent in the

location pattern of doctors.

Training of Health Humanpower : The training of health humanpower is carried out in properly established institutions having affiliation to the University or Board, also having attachment to the hospital for giving practical training to students and above all supervised by the Medical Councils constituted under the law. All these suggest that we expect information on the humanpower trained to be highly reliable. Unfortunately the quality of data available belies such expectations.

We could compile time-series data on the training only of allopathic doctors, dentists and nurses. Such data on the training of doctors from the other systems of medicine are not available. Of the paramedical personnel, ANMs, MPWs and HAs are specifically trained for the government public health services and most of them are appointed in the rural areas after completion of training. The content of their training and the skills imparted are such that only a very small proportion of them would find employment outside the public sector. Therefore, one can safely assume that most of them are trained to meet the demands of the PHC infrastructures. That is why in the training of these paramedics, a need-based training approach dominates. Thus in these categories of workers, we find a sudden increase in the out-turn in those years when rapid expansion of the government health infrastructure was undertaken. The latest expansion programme was started in 1984 when the government accepted the norm of having one PHC for 30,000 population in the non-tribal areas and one PHC for 20,000 population in the tribal areas. Simultaneously it was decided to have one sub-centre with two paramedics for 5,000 population in the non-tribal areas and for 3,000 population in the tribal areas. As a result the requirement of the paramedics has increased. For example, in 1982, the out-turn of ANMs in India was 6,192. This out-turn showed a marginal decline in 1983 as only 6,006 ANMs were trained that year. However, in 1984 the out-turn increased to 8,937 and showed further increase to 9,694 in 1985.

The training situation for doctors and nurses is however different. There is no attempt made to train them or even a proportion of them exclusively for the public sector services. After training, only a small minority accepts employment in the government services, whereas the rest directly enter the health care market which is almost entirely curative oriented. The content of their education and the skills imparted therefore do not directly reflect the needs of the public sector health care and indeed never reflect the needs of the rural population.

Training Infrastructure : It comprises of medical colleges, dental colleges and the nursing training institutions.

Unfortunately, we do not have consistent and dependable data on the training infrastructure for doctors of non-allopathic systems of medicine. In Table 5 (Appendix I) we have compiled data on

the training infrastructure for the non-allopathic systems of medicine. Although these data are deficient (due to non-availability of information from some States and training colleges), they reveal some patterns. There are 222 **non-allopathic medical colleges**, of which 65% (144) are controlled by the private sectors. Many of these private colleges evidently receive substantial government financial aid. As the table shows, the highest number of colleges are those of homeopathy (105) and of them the highest proportion (79 or 75.2%) is private.

In 1986 there were 123 **medical colleges for the allopathic system of medicine** and of them 21 or 17% were controlled by the private sector (see Table 6 in Appendix I). The medical colleges for the allopathic system have shown a remarkable increase in number since Independence. In 1950, there were only 28 such colleges and by 1987 there were 125 of them, an increase of 4.4 times. The share of private colleges has also increased from 3.6% in 1950 to 17.1% in 1986. The increase in the number of private colleges between 1950 and 1979 was not so spectacular as in those thirty years only, nine more private colleges were added. But in the next seven years, i.e. between 1980-86, eleven more private colleges were established. The Fifth (1974-79), Sixth (1980-85) and Seventh (1985-90) Five Year Plan were emphatically stating that the doctors were overproduced in our country, and that no more medical colleges be established or the admission capacity of the existing colleges be increased; yet between 1974 and 1986, eighteen new medical colleges were added, 12 (66.7%) of them in the private sector.

All in all, in 1986 our country had 345 medical colleges of all systems of medicine and of them, 47.8% were located in the private sector.

The increase in the number of **dental colleges** is also fairly rapid, with a spurt in growth observed in the 1980s. Their number increased from seventeen in 1979 to forty in 1987, i.e. in eight years twenty three new dental colleges were added in our country. Unfortunately, we do not have information on the share of private sector in the number of dental colleges.

The **nursing institutions** for training on the other hand, have not grown at the same rate. The institutions for the graduation degree in nursing have increased from two in 1950 to eight in 1983, whereas the other institutions offering training in the general nursing have grown from 227 to 386 in 1986.

Out-turn of Health Personnel : The data on the out-turn of **non-allopathic doctors** seem grossly incomplete, for as against the admission capacity of 10,521 in all non-allopathic colleges, in 1986, the out-turn in 1985 was reportedly only 3,970. It is interesting to note that of the total 10,521 admitted in the non-allopathic colleges in 1986, 67.3% (or 7,181) were admitted in the private colleges.

The out-turn of **allopathic doctors** has increased very rapidly (see Table 7 in Appendix I). In 1950 India was producing 1,557 doctors in a year. In 1977, it produced 13,783 doctors. Surprisingly since 1978 the data on the out-turn of allopathic doctors are consistently incomplete and evidently no effort is made to provide completed data. But it is easy to guess that between 1977 and 1987, given the increase in the number of colleges, the out-turn of doctors might have significantly increased. We would not be wide off the mark in suggesting that the out-turn in 1987 was over 15,000.

If we take all systems of medicine together, it seems that the out-turn of doctors is much much above 20,000 per annum.

A similar growth in the out-turn of **dentists** has taken place. From an out-turn of 14 in 1950 it has increased to 660 in 1987. Similarly, trend towards **specialization** in the allopathic doctors and dentists is getting stronger and stronger. The data suggest that about one third of doctors and dentists go for post-graduate training after completing their graduation.

The increase in the out-turn of **nurses** is quite modest over the years. In 1950, the out-turn was very low, being of 14 for the B.Sc. nursing and 1,282 for the general nursing. In 1983, the out-turn of B.Sc. nursing was 315 and that of general nursing was 7,750.

Private Sector in Training : As we discussed earlier, the stated objective of welfare State is reduction of inequality and redistribution of wealth. Many studies have shown that despite government's direct participation in the medical education (allopathic), the caste and class backgrounds of doctors have persistently shown bias towards upper castes and classes (see Oommen, 1978; Madan, 1980; Venkataratnam, 1979 and Chandani, 1985). That is, the State intervention in the medical education in our country has not been successful in providing substantial opportunities to the depressed strata of people to become doctors.

In this situation the trend towards private medical colleges is even more alarming. For more and more medical colleges are being set up in violation of all policy statements made since the Fifth Five Year Plan. For two third of new colleges established in the last seven years are in the private sector. For the private sector colleges charge exorbitant capitation fees to get admission and the annual fee payable in these private colleges is ten to fifteen times more than that charged in the government colleges (Kothari, 1986). Further, according to one newspaper report (Qureshi, 1989), in the State of Karnataka which is having 12 private colleges, one was conducting classes in a corporation school and was putting the government hospitals and colleges under strain by sending its students there for the training. Such examples can be multiplied as in the last few years, due to the junior doctors' agitation against the capitation colleges,

the media has carried numerous reports on the activities of private medical colleges. On certain aspects, these reports seem to be unanimous. That these colleges are big profit spinning business ventures. That these colleges are beyond the reach not only of the lower classes but also of the middle classes as they charge exorbitant capitation sums. That many of these colleges do not have adequate teaching and training infrastructure thus substantially lowering the standards of medical education. That these colleges have strong political patronage. That such patronage is useful to them for utilising the government health care infrastructure for training students at very low cost.

In short, the mushrooming of the private colleges is to say the least, compounding the failure of welfare intervention of the State medical education. These colleges would not provide any opportunity to the lower stratas to get medical education. Contrary to claims, they have not contributed in reducing the rural-urban disparity in the distribution of doctors as the students making high investment would find the urban areas more conducive to get substantial returns on the investment. Further, since the private colleges make the private investment in medical education so huge, the resultant doctors would tend to prefer high cost, high technology medicine in order to get substantial returns. This together with the inevitable malpractice has further increased the cost of medical care without improvement in quality or distribution of service.

Thus one should not just look at the private sector medical education but should also understand the logical spin-off action that the private medical education heralds. And in violation of all policy statements, the involvement of politicians, the State bodies like Universities and Boards, the Statutory bodies like Medical Councils, the private and nationalized banks and so on; in giving a big boost to the private medical education and also in offering more and more government infrastructural facilities to these private colleges are really of serious concern.

Out Migration of Doctors : The out migration of doctors has been identified by scholars as a major issue of concern for the underdeveloped countries. It is also argued that by transplanting medical professionalism and advanced medical technology in the underdeveloped countries, the developed countries have gained economically as well as indirectly by attracting trained humanpower (Brown, 1979). The out migration of Indian doctors is also studied by scholars (e.g. see Ishi, 1989).

Table 8 in Appendix I, gives the information on doctors migration from 1950 to 1986, and compares it with the out-turn of doctors. In the period 1970-74, the average annual **net** migration of the Indian doctors was 1,590, which was 14.2% of the average annual out-turn of doctors in the same period. Since then, the average annual net migration has increased, being 2,643 per year in the 1984-86 period. But as we do not have exact figures of the out-

turn of doctors in the last ten years, it is not possible to calculate the proportion of migration. However, our estimate is that the **net** migration is still somewhere between 15 to 20% of the total out-turn every year. This indeed is a substantial loss, both economically as well as to the health care services which need more health workers to provide health care in the rural areas. It must be remembered that the majority of migrating doctors have been trained at public expense in government medical colleges.

The Health Care Infrastructure

In our country the Primary Health Centre infrastructure is exclusively for the rural areas. After Independence the building of the PHC infrastructure was begun and by 1988, 14,145 of them were set up. It is interesting to note that upto 1983, there were only 5,954 PHCs in the country and the additional 8,191 were set up in the next five years. Thus, substantial number of the new PHCs do not yet have their buildings and other facilities. In any case, even a fully functional PHC provides only out patient care, implements public health and family welfare programmes and also conducts deliveries.

Rural-Urban Distribution : Table 9 in Appendix I, provides time series data on the rural-urban distribution of hospitals, dispensaries and the beds. Accordingly, between 1951 and 1988 the number of **hospitals** has increased 3.5 folds, **dispensaries** 4.2 times, and **hospital beds** 5 times. However, this increase has not brought about any important benefits to the rural masses. In fact, the proportion of rural hospitals has actually declined from 39.3% in 1956 to 26.4% in 1983. Since 1983, there is slight increase in the number of hospitals in the rural areas (perhaps due to establishment of the Community Health Centres) and thus in 1988, 31.5% of hospitals were rurally located. The proportion of rurally located dispensaries has shown great fluctuations over time due to policy of the government. In 1956, 84% of all dispensaries were rurally located. This proportion progressively declined to 68.6 in 1983. But between 1983 and 1988 though more than 10,000 new dispensaries were added in the period, the proportion of the rurally located dispensaries showed a very sharp decline with only 47.35 being rurally located in 1988. This was perhaps due to the conversion of rural dispensaries into PHCs in the period and also due to the establishment of most of the new dispensaries in the urban areas. Similarly, the proportion of the rurally located hospital beds has declined from 23% in 1956 to only 13.5% in 1983.

Sectoral Distribution : The Table 10 in Appendix I, shows the public-private sectors distribution of hospitals and hospital beds. The table shows very clearly that between 1974 and 1988 the number of **hospitals** in the private sector has grown very fast, its proportion increasing from 18.6% of the total in 1974 to 56% of the total in 1988. However, the corresponding increase in the share of private sector **hospital beds** in the same period

is very modest, as it increased from 21.5% of the total in 1974 to 30% of the total in 1988. The Table 11 in Appendix I, further clarifies that the number of private **hospitals** increased by 43.07% per year between 1974-79, by 12.06% per year between 1979-84 and 17.21% per year between 1984-88. The growth of the government hospitals in these periods was 6.37%, 1.02% and 2.61% respectively. However, the rate of growth of hospitals beds is slow. In the private sector, the number of hospital beds increased by 20.09% per year in 1974-79, 3.86% in 1979-84 and 6.81% in 1984-88 periods. The corresponding growth rate of hospital beds in the government sector was 11.35%, 1.92% and 3.29% per annum respectively in these periods. Thus, in the last one and half decades, the hospitals and the hospital beds in the private sector have grown very fast as compared to those in the government sector.

The growth of **private dispensaries** is really phenomenal. When the number of government dispensaries grew only from 13,205 in 1981 to 13,916 in 1988, the private dispensaries increased from 2,115 to 13,579 in the same period, (See Table 12, Appendix I). The private sector share in the total number of dispensaries also grew from 13.8% of the total in 1981 to 49.4% of the total in 1988. It is interesting to note that most of the private dispensaries do not have beds. The Table 13 shows the growth rate in the number of dispensaries and the dispensary beds.

Although available data provide ample evidence that there is a phenomenal growth of private sector in the hospital based health care facilities, these data are, to say the least, grossly incomplete. Any time in future when full real picture emerges, we can confidently predict that it will show greater control that private sector has on the hospital based health care. Two recent events prompt us to make this prediction. From 1989 the Bombay Group of Medico Friend Circle (MFC) a group of health activists, concentrated its attention on private hospitals (PHs) and nursing homes (NHs) in Bombay city. In a public interest litigation filed before the Bombay High Court, it was revealed that the list of private NHs and PHs provided by the Municipal Corporation was incomplete as 20 to 40% of functioning NHs were unregistered. The Corporation also did not have the information on actual number of beds in these NHs and PHs. Similarly, the Delhi administration discovered that of over 545 NHs and PHs functioning in the city, only 134 (24.6% or less) were registered (Raina, 1992). Obviously the Bombay Nursing Homes Registration Act (BNHRA) of 1949 and Delhi Nursing Homes Registration Act of 1953 were never properly implemented, resulting into highly deficient data. Further, the BNHRA of 1949 is applicable to the whole of Maharashtra (urban as well as rural) but its implementation is even tardier in other big cities and non-existent in the rest of urban and rural areas. To compound this, the MFC also discovered that a majority of States (including Gujarat and Kerala where private sector has flourished) in our country do not have even such a paper Act for registration of PHs and NHs.

Thus, one can safely say that once all PHs and NHs, and hospital beds under them are accounted for, the share of govt. sector in hospital care may significantly come down.

Corporatisation of Health Care : The fast growth in the private curative medical care is also reflected in the changing organisation of health care delivery. The penetration of large business houses in the business of health care delivery has grown in the last one and half decades. Recently the government made a minor but important change and declared the hospital as an industry thus making it eligible to receive money from the financial institutions and to raise capital by issuing shares in the stock market.

It should be note that expansion of diagnostic centres with hi-tech instrumentation and the modern hospitals, particularly in the private sector, has not taken place without the government coming to know about it. On the contrary, it seems that the government has consciously participated in this expansion by the public finance institutions providing the needed finances and by the liberalisation of imports. Further, for example, in March 1983, the government set up a Hospital Services Consultant Corporation (India) Ltd., to provide expert help in setting up modern hospitals and diagnostic centres, in the installation of high-tech instruments and their maintenance in our country as well as abroad. This help is provided by the Corporation to the public as well as the private sectors in India. The Corporation is actually the only profit-making body of the Health Ministry as it declared a 15% dividend on the paid up capital for the year 1987-88 (GOI, 1988-89: 23-24).

Since a detailed discussion on the government policies is not possible here, it is sufficient to note that, notwithstanding all stated policies in favour of community health, these vital segments of health care delivery in the private sector are actually de-linked from the community health orientation and are in all probability treated on par with any other industrial venture. As a result we observe that the profitability criteria in the running of hospitals and diagnostic centres are superceding the social cost-effectiveness criteria of the community health care enshrined in the government policies (for detailed information on the Corporatisation of Health Care, please refer to **(Appendix II)**.

PRODUCTION OF MEDICAL TECHNOLOGIES

The Office of Technology Assessment (OTA) of the USA (1980) defines medical technology as "the drugs, devices and medical and surgical procedures used in medical care, and the organisational and support systems within which such care is provided". Obviously we cannot cover all such technologies in our brief review. However, we have already mentioned that both the private

and public sectors are actively involved in setting up modern hospitals and diagnostic centres. Further, in the construction of hospitals, PHCs, Sub-centres, CHCs, etc., the government has provided contracts to the private sector. Unfortunately no information on the quality of private participation for the construction of public sector institutions has ever been made available. For the benefit of the ongoing debate on privatisation of health care services it is imperative that a survey of contracting out construction of buildings for the public sector to the private sector is undertaken and the quality and efficiency of work rendered by the private sector is properly assessed.

Production of Drugs and Pharmaceuticals : Table 14 (Appendix I) shows the sector-wise production of bulk drugs and formulations. In the production of bulk drugs, earlier the public sector played a leading role and provided a big proportion of them to the private sector for the production of formulations. This can be easily grasped as the production of formulation by the public sector has consistently remained low. However, as shown in the Table 14, the proportion of public sector production of bulk drugs is progressively declining as the private sector is showing increasing activity. In the production of formulations, on the other hand, we find only a marginal increase in the proportion of public sector production over the years. Thus the private sector drug industry is showing fast growth and has overshadowed the public sector contribution.

Production of Medical Equipments : Production of medical equipment was started in the seventies in India and has grown from Rs.2.5 crores in the earlier years to Rs.19 crores in 1983 (CEI, undated). Today, a wide variety of the new medical equipment is being manufactured (or assembled) in India. Among them are electro-cardiogram (ECG), X-ray machines, cardiac pacemakers, foetal monitors and so on. However, given the fast growth of hi-tech medical care and the demand for the "latest" Western technologies like the CAT Scan and others, the import of instruments has increased. It is estimated that nearly 80% of all medical equipments are imported through private companies (Baru, 1988, CEI, undated). The increasing demand for the hi-tech medical instruments can be understood from the fact that while the Sixth Five Year Plan (Planning Commission, 1980: 275) estimated it at Rs.30 crores in 1984-85, according to the Confederation of Engineering Industries (CEI, undated), the Working Group on Electronics for the Seventh Five Year Plan estimated it around Rs.900 crores for the plan period.

Table 15 (Appendix I) shows India's exports and imports of medical equipment and it is very clear that in 1986-87, our country exported equipments worth Rs.7 crores against the import of Rs.65 crores. This is due to the liberalisation of import policy by the government and the media has taken note of it in respect of the medical equipment (TOI, 1988, Rao, 1989). According to these reports, the government now allows 237 types

of equipment for imports without insisting on the "Not Manufactured in India" (NMI) certificate. In the case of the central or the government aided hospitals, only the head of the institution need certify the NMI. Even for the private hospitals, the NMI certificate is not needed provided a certificate from the Directorate General of Health Services is obtained. Thus the linkage between the import and the export of medical equipments is loosened leading to the fast growth in imports and the high negative balance of trade in the medical equipment. Further a study by the Reserve Bank of India (1988) found that the private corporate sector took advantage of import liberalisation policies without concomitant contribution to export promotion.

FINANCING HEALTH CARE SERVICES

Data on the health care financing are not systematically compiled and adequately analysed in our country. The ICMR/ICSSR Committee (1981) identified this problem very clearly when it stated that "It is a pity that problems of the economics of health and financing of health care services have received little attention in this country. Very little meaningful data is available on the subject. There is hardly any analysis of issues like the different sources and objectives of the total expenditure on health, cost effectiveness of different programmes, efficiency and waste in the system and so on".

Expenditure on Medical Education : This is a very important area, for the medical education is largely financed by the State and an overwhelming majority of doctors trained at the State expense join the private health care sector. Recently Ravi Duggal (1989) of the FRCH has done a good study of this subject. Table 16 and 17 in Appendix I were compiled by the FRCH research team show plan-wise medical expenditure in India and the Medical Education and the teaching hospital Expenditure in Maharashtra from 1981 to 1989 respectively. The data for the former were collected from the combined Finance and Revenue Accounts, 1951-52 to 1982-83 and the CAG reports of various years, whereas the data for the latter were collected from the Maharashtra Government's Performance Budgets. All information is about the expenditure for the **allopathic** medical education.

Table 16 shows that the revenue expenditure on medical education has increased from Rs.1.3 crores per annum in the 1952-56 period (1st Plan) to Rs.118.7 crores per annum in the 1980-83 period. The expenditure is almost fully by the State can be seen from the fact that the percent of expenditure received as fees has declined from 28.7% in 1952-56 to 1.7% in 1980-83. In the period 1980-83, the combined revenue and capital expenditure on medical education was Rs.146.7 crores per year. Further the share of medical education expenditure in the medical services expenditure has increased from 5.33% in 1952-56 to 13.33% in 1980-83.

Similarly the share of medical education expenditure in the total health expenditure has increased from 3.47% in 1952-56 to 7.21% in 1975-79, but slightly declined to 6.95% in 1980-83.

No reliable data on the amount spent by the government to educate one allopathic doctor are available. In most of the estimates, the money spent on teaching hospital is not counted although it is clearly known that without teaching hospital infrastructure doctors can not be trained. Duggal (1989) has made a rough estimation of the cost to the State on training one doctor by using the data on teaching hospital and medical education expenditures in Maharashtra for the year 1983 (Table 17 in Appendix I). He has excluded from his calculation, the expenditure on 3 municipality owned medical colleges and hospitals, the capital expenditure and the administrative costs. Since between 1981 to 1983, on an average 84% of the medical education expenditure was spent on medical colleges, and the rest on other personnel, that proportion (84% of expenditure) was taken for calculation from the medical education expenditure and the teaching hospital expenditure. Accordingly he arrives at the medical college expenditure of Rs.84,951.78 per doctor in the year 1983. Similarly he arrives at the teaching hospital expenditure of Rs.3,12,742.37 per allopathic doctor's training in the year 1983. Both combined makes total cost of Rs.3,97,694.15 per doctor.

This methodology would undoubtedly raise some objection because it can be argued that cost of teaching hospital (even after discounting 16% of administrative and other personnel cost) should not be fully taken as the cost of educating the doctor as the teaching hospitals also provide service to the community. However, we believe that even if one takes about 50% to 75% of the teaching hospital cost as the expenditure towards training doctors, the total cost per doctor per annum would be in the range of Rs.2,50,000 to Rs.3,25,000/-.

If we take a considerably lower figure of the average cost for training one doctor at Rs.3,00,000 (about 25% less the Ravi Duggal's estimate) and given the minimum production of 15,000 doctors in a year; then the State is spending about 450 crores every year for training doctors in our country.

This estimation of medical training expenditure throws light on many things. Firstly, the above estimation is based on 1983 figures, so the current expenditure would be more. Secondly, most of the allopathic medical colleges are in the urban areas, thus it increased the government urban health care expenditure at the detriment of the rural areas. Thirdly, over 80% of doctors qualifying every year join the private health care sector. Thus, above 80% of the State expenditure (i.e. about 350 crores of 450 crores) on training doctors is effectively spent for supplying doctors to the private sector every year. And lastly, the urban area and private sector as the final destination of doctors, orient the content of the medical education to the service of

those sectors rather than the needs of the rural areas and the public sector.

Needless to add that unless these basic problems of urban orientation and supply of doctors for private sector health care are effectively tackled by reallocating the medical education expenditure in the favour of rural areas and the public sector health care needs, it will not be possible to produce basic doctors to meet the health care needs of the masses.

Health Care Financing : Ravi Duggal and Dr. N.H. Antia (1988) have done a concise review of various studies on the health care financing in India and have also pointed out serious gaps in information on the subject. Due to limited space, we do not go into the details of those studies.

The third round of the NSS (1951) recorded Rs.5.77 per capita per year as private health expenditure. When we add the State health care expenditure of 1951-52 in it, the total works out to Rs.6.63 per capita per year and this is 2.53% of GDP. Thus, in 1951-52, the private health expenditure was 6.7 times of the State health expenditure. The 28th round of the NSS in 1973-74 estimated the private health expenditure at Rs.14.05 per capita which was three times over and above the State expenditure in the same year. Duggal and Amin (1989: xiv) in their recently published study, while reviewing the NSS data and the data from other micro-studies, have come to the conclusion that 70% of the health care expenditure is in the private sector.

The most recent evidence on the health care expenditure is available in a study of health expenditure as 600 sample households (264 urban, 336 rural) in Jalgaon district of Maharashtra (a socio-economically average district in the country with the Centre for Monitoring Indian Economy's socio-economic index score being 100) by Duggal and Amin (1989) of FRCH. They found that in 1987 the household expenditure on health care was Rs.182.49 per capita per annum. To this they added the health care expenditure in 1987 by the government, municipal bodies, the corporate sector and the ESIS in Jalgaon district and found that the total health expenditure was Rs.213.44 per capita in 1987. Thus, the private or out of pocket expenditure by the households was 81.98% of the total. Further they estimated that the total expenditure on health care works out to be 7.01% of the domestic product of Jalgaon for the year 1987. These data were corrected by them for double counting, reimbursement etc. and they arrived at total health care expenditure at Rs.192.10 per capita, which is 6.31% of the Jalgaon district's net domestic product.

In short, there is increasing evidence available now that due to rapid expansion of the private health care sector, the irregularity and corruption in the public health care sector (Duggal and Amin have collected information on the bribe paid by households while utilising government services) and above all the underdevelopment of the government health care services; the

private health care expenditure has shown phenomenal increase. The State health expenditure has on the other hand, lagged behind.

CHAPTER FOUR

MEDICAL PRACTICE IN PUBLIC AND PRIVATE SECTORS OF HEALTH CARE

What role does medicine play in improving the health status of the people? This question is of fundamental importance, but its answer is more-or-less practically settled by the research done in last one and half centuries. As early as in the mid-19th century Rudolf Virchow who did pioneering work in the study of infectious diseases and epidemiology, stressed the importance of social, economic and political factors (Waitzkin, 1984). He indeed coined the slogan that "Medicine is a social science and politics nothing but medicine on a grand scale" (Rosen, 1947; Rather, 1983:xiii). These views of Virchow are repeatedly reinforced by many researchers since then. Only a decade back, Thomas Mckeown (1979) did historical analysis of data on the developments in the **socio-economic** fields, their effect on the health of the people and the contribution made by the medicine. He concluded that though the clinical medicine had its own place in health care, the other factors like nutrition, environment, behaviour etc. had long term impact on the health status. It is now widely accepted and also reinforced in the Alma Ata Declaration (WHO, 1978) that the health should be viewed as a part of development and the political will of the government plays a decisive role in orienting development for improving the health of the people.

Nature of Medical Practice : Since the health care services also contribute, albeit in a limited way, in the improvement of health status, it is relevant to ask : what should be the nature of medical practice so that it could make maximum contribution in the nation's efforts to achieve better health status for the people? The way this question is framed shows that we are not talking about the role of medical personnel in tackling socio-economic factors affecting the health status. The medical personnel involving themselves in the socio-economic issues is an ideal discussed by many but practised by very few. Here the question covers limited ground, that even if we accept that social, economic and political issues are beyond the scope of medical personnel, what should be the nature of medical practice in order to make it the most effective? For underdeveloped countries which, for obvious reasons can not afford high cost medicine, this question is of great relevance.

In 1948, in Britain, the public health functions were excluded from the main responsibility of the National Health Services (Stewart, 1987). However, the same was not the case in India. The Bhore Committee Report (1946) while emphasising the need for rapid socio-economic development for the success of its health care plan, did not want the medical practice to remain confined to its traditional role of curative care and simply wait for the socio-economic development to improve the health status of the people. It in fact wanted to orient the medical practice to

actively aid in the improvement of health status. Thus, it suggested that "preventive and curative work should be dovetailed into each other in order to produce the maximum results" (ibid:24). This was argued not from an idealist and a moralist standpoint but from a very practical concern for the interests of the community and of the professional efficiency of the medical personnel. It stated that "a combination of curative and preventive health work is in the best interest of the community and of the professional efficiency of the medical staff employed. In fact the two functions cannot be separated without detriment to the health of the community" (ibid:40). The National Planning Committee Report (1948), too, emphasised on the integration of curative and preventive health care functions.

Comprehensive Medical Practice : Public and Private Sectors

The health care in the private sector has been almost entirely curative in nature. Of late, the public sector efforts at creating consciousness about immunisation and its actual provision through high-powered target oriented programmes, have created substantial market or demand for immunisation in the private sector, too. Thus, many private practitioners now-a-days provide immunisation services. But the comprehensive or integrated medical approach is otherwise effectively ignored by the private sector.

It is easy to surmise from this that the overwhelming majority of doctors (estimated to be over 85% of all systems of medicine) working in the private sector, practise chiefly curative medicine. Not only that, since the expansion of the private sector is taking place rapidly and account for over 80% of health expenditure of the country, the overall trend is towards curative medical care. This is indeed highly detrimental to the interest of the community and is progressively reducing the **social efficiency** of the medical profession in making contribution towards improving the health status of the people. Thus, it is clear that the greater the importance is given to the private sector (which is not controlled in the health planning process), the more reinforcement will be provided to the almost exclusively curative medical practice.

In the public sector, on the other hand, the situation is a mixed one. The urban component of the public sector in many ways resembles the medical practice in the private sector. And indeed a greater part of the public health care sector resources is spent on urban health care. This is also true for the recently created rural hospitals or community health centers (CHCs). Contrary to what the ICSSR/ICMR Committee (1981) envisaged, the CHCs instead of becoming the center of planning and providing the community health care (with an epidemiological orientation), have been reduced to become the curative center for the 100,000 population in the rural areas.

However, when we take the Primary Health Center (PHC) infrastructure separately, a different picture emerges. All the health workers at the PHC and the sub-center are oriented to practice comprehensive medical care. This does not apply only to the doctor who is the leader of the health team at the PHC, but also to the paramedical staff. The paramedical staff - the health workers and the health assistants - are supposed to provide curative, preventive and promotive health care. The paramedics are no longer trained only to help the doctor in his or her work, but are trained to provide all aspects of health care in a relatively autonomous manner. The paramedics are also required to run sub-centers, with drugs made available for curative care; and the doctor normally supervises from a distance as the doctor is located at the PHC. A lot is written about the weak motivation of the doctor in undertaking preventive and promotive activities but nevertheless as a team leader the doctor is accountable for the performance in those two fields. Thus, at least, he comes under administrative pressure to pay attention to the preventive and promotive work. The now largely defunct Village Health Guides, were also trained in order to provide comprehensive primary health care.

In a study conducted by the Foundation for Research in Community Health in 1987-88 of PHCs in Maharashtra for the State government, using anthropological and qualitative methodology, we found that the PHC staff was primarily concerned about the fulfillment of targets assigned to them in the preventive and the promotive health field. As a part of this study we interviewed 30 **ANMs** at the PHC and the sub-center level. 63% of them said that the Family Planning programme was most emphasised in their work by the government. The other programmes listed were immunization (13%), MCH (17%) etc. They also stated that they spent maximum time on these works and minimum on the curative care. The major complaint against the PHC in the rural area by the people has been normally about its inability to provide curative care and about its excessive campaigns on the preventive and the promotive care. We found that when the PHC doctors attended the district level meetings of medical officers presided over by the District Health Officers the evaluation of the performance of the individual PHC and the doctor weighed heavily in favour of the preventive and the promotive programmes whereas the problems related to the curative services were rarely raised and almost never discussed (Jesani, 1989).

Thus, unlike the private sector and the urban public sector, the medical practice in the rural PHCs is clearly sought to be oriented towards comprehensive care. This does not mean that this orientation has been successfully implemented in actual practice. Almost all government reports, committee reports and numerous studies have shown the inadequacies in implementation. But at the same time it is becoming evident that what Takulia, Taylor et.al. (1967:55) recommended in their study of "The Health Center Doctor in India" that "The new structure should provide a supervisory system which would preclude neglect of preventive

medicine by the health center doctor, even if he is not prevention-minded", has struck some roots in practice at the PHC level in many parts of the country. One can easily quote from the findings on the irregularities and malpractices in the supervisory functions, including those by the doctor, but one can not ignore that as a part of the PHC structure, the doctor cannot afford to completely neglect preventive health care. Further, when we compare the functions carried out by the doctor at the PHC with those by the doctor at the government dispensary in the rural areas and those by the rural private practitioner, we would be less inclined to pass a sweeping judgement against the PHC doctor.

In summing up, we may say that the preponderance of curative medical practice in the health care services in our country is chiefly due, directly or indirectly, to the domination of the private sector. This is compounded by the government's almost non-implementation of the preventive care orientation in the urban public health sector and its weak implementation in the rural public health care sector. All these combined contribute to the low overall social and professional efficiency of the health care services in our country. And indeed this situation, as the Bhore Committee had put it, is detrimental to the interest of the community.

Now let us examine what is the condition of the curative health care, which is the chief consideration of the private sector?

Private Sector Curative Medical Practice

Although a lot has been written about the curative care orientation of the health care services in India, very little is written about how the curative care is actually practised. Further, from a traditional market orientation perspective, one would expect that as more doctors are produced, their internal competition and the saturation of the market would progressively force them to locate themselves in the under-served areas, and thereby the market would bring about some redistribution of doctors. However, as we showed in chapter two, instead of the market pushing doctors to the under-served rural areas, they are getting more and more absorbed in the urban areas.

This progressive "de-ruralisation" of doctors over the last three decades indicates that the volume of the urban curative health care market is expanding. Thus, on one hand there is a "market failure" in terms of locating doctors and health care facilities; and on the other hand, the urban curative care market is fast expanding. The pertinent question, therefore, is whether the latter is taking place at the determent of rational and ethical medical practice.

Changes in the Organisation of Curative Medical Practice : Traditional organization of curative medical practice revolves around the preponderance of General Practitioners, Family

Physicians and Consultants. The first two categories could be combined in a single practitioner in the sense that the family physician is normally a general practitioner but all general practitioners are not family physicians. In the traditional organisation of medical practice, the consultant plays a role of specialist to whom the GP/FP refers cases for getting advise on diagnosis and the line of treatment to be pursued in cases requiring greater skill or facilities. This organisation of medical practice is so ingrained that the code of medical ethics has laid down certain general rules regards the relationship between the GP and the consultant.

But this traditional relationship between the GP and the consultant is undergoing a profound change. Dr. C.N. Chandrachud (1970:84) in his "Memories of an Indian Doctor" observed that now "it is common for a consultant to see and examine a patient without being called in by a general practitioner. A consultant often deals directly with the patient and carries out further the job of giving injections etc. I have known consultant who have maintained dispensaries much against the rules and dispenses medicines in the dispensary. Some of the consultants have almost made it a rule to ask a patient to seek consultation after a week or fortnight and tempt the patient with the offer that the fees for the next consultation would be half of what was charged for the first consultation". It need not be added that what Dr. Chandrachud observed in the 1950s and 1960s as a growing unethical behaviour of the consultant has now become an established practise. It is true indeed that the intense market competition and the profit orientation, in the virtual absence of adequate machinery to implement professional self-regulation does not honour old traditions nor the traditional code of ethics.

The doctor is undoubtedly a professional and this status is due to his or her acquired knowledge, special skill and the position he or she occupies in the process of curing illness. However, this does not mean that his/her location in the economic system remains unchanged. Sometimes it is argued that "the GP is actually engaged in a pre-capitalist mode of production, but nevertheless produces commodity of use value and sells it for an exchange value. Our much maligned GP is..... just a small commodity producer....." (Das, 1985: 59). But this is only partially true. As a petty commodity producer, the doctor does own his or her skill and certain instruments for providing services. However, the relationship between the customer (patient), the trade-person (doctor) and the technology used for curing (drugs) is no longer of old type in the sense that the industry has almost thoroughly penetrated this relationship. Since the doctor as a professional is essential for the sale and the use of goods produced by the health care industry, he or she while acting as "a small commodity producer" simultaneously works as an "agent" (or a sales person) of the industry in the market for the realisation of profit. This new role of doctor is almost universal because he or she no longer gathers herbs and chemicals, and compounds drugs. The increasing technological use

in diagnosis and the treatment has, therefore, changed the practice of medicine from caring to mere curing.

Thus, the changes in the organisational set up of the individual medical practice are not limited to the change in the doctor-doctor relationship and the doctor-patient relationship but the very social position of the doctor as a health care provider has changed. The doctor has indeed become an essential part of the market strategy of the health care industry.

For-profit medical care : The convergence of the interests of the industry and the practicing doctor takes place most visibly in the for-profit medical care. In our country the private sector almost exclusively works on user charges, because insurance coverage is negligible. Even where the State partially provides insurance, as is the case with industrial workers, the situation is not so rosy. In the Employees State Insurance Scheme, the upper limit of the salary for getting covered under the scheme is not connected to increase in salary due to inflation (or what is called dearness allowance). In 1982-83, the arrear in collecting employer's contribution to the insurance was as high as Rs.41 crores. While no spectacular growth in the actual provision of services is found, the ESI corporation had in 1982-83 over Rs.336 crores balance amount kept invested in various places (Bhatnagar, 1985). Such an insurance scheme has not helped in making any significant dent in the practice of taking user charges in the urban areas. The insurance schemes like Mediclaim by the United India Insurance have actually helped in the increasing usage of hi-tech, high-cost medical care in the private sector.

In our country there is no restriction or no guidelines from the Medical Council or the State on the quantum of fees charged by the doctor, the nursing home or the hospital. In the for-profit private sector this situation has encouraged increasing of charges especially by the experienced and well known doctors. It is also observed that such doctors earn disproportionately high income as compared to their declared income. If the reports appearing in the print media is any indication of the trend, then the complaints of the under-the-table charges by doctors and hospitals are on the increase.

In contrast to this observed trend, no reliable information on the earnings of doctors is available. The income-tax authorities have not published any survey of medical profession's income at any time. In a study of 152 doctors (119 of them working in institutions) located in Jodhpur City (Rajasthan) by Ambika Chandani (1985:32), it was found that the average income of private medical practitioners from their practice was Rs.783.80 per month. For the entire sample, she found that the monthly average income of doctors was Rs.950.60. This is undoubtedly a ridiculously low figure for the income of city based doctors. Mercifully, some scholar have recently paid attention to this lacunae and done exploratory/pilot studies on doctors' income. Alex George (1991) in a survey of 33 doctors (General

practitioners/specialists and allopaths/non-allopaths) in Bombay found that their average net income was Rs.18,333/-. But in a relatively larger survey of 177 doctors in Delhi done by the Indian Statistical Institute (ISI), it was found that the average net income of a doctor practising at clinic/residence was Rs.29,800/- per month and of a doctor running a nursing home it was Rs.80,000/- per month (Kansal, 1992). These findings indeed confirm our earlier diagnosis of profiteering in the for-profit medical care, if not generally, at least in respect of our metropolitan centers.

While millions of people in the rural areas have no access to basic health care, in the urban areas where the curative care medical practice is highly concentrated, the rising cost of medical care is becoming an important issue. This rise in cost is not related only to the earnings of doctors, but also to the usage of high technology. The schemes sponsored by various Indian, Non-Resident Indians and other organisations, often with the blessing of the Medical Council and the Government, for training Indian doctors in the latest medical technologies are on the increase (Chatterjee, 1985: 17). In Chapter Three we have discussed the increasing production and imports of hi-tech medical instruments. In addition to increasing cost, this trend is also encouraging a tendency to directly advertise such technology to the general public. This becomes necessary because the investment involved in the purchase, housing and maintaining such instruments run into crores and in the market set-up, for getting adequate return on such investment, continuous and unnecessary use of the instrument becomes an economic necessity (Awasthi, 1988).

Irrational Medical Practice : The issue of over-medicalisation and iatrogenesis were forcefully raised by Ivan Illich (1975) and Ian Kennedy (1981). Such issues have equal relevance in our country. In the last one decade, the efforts of the constituent organisations of the All India Drug Action Network, Kerala Sastra Sahitya Parishad and many other such socially oriented health, science, women and consumer organisations have helped focus our attention to the production and sale of irrational medical goods and their use by doctors. Modak (1984), Phadke (undated), Jayarao (1985) and many other have painstakingly done scientific scrutiny of drugs produced by the industry and used by doctors. The ICSSR/ICMR Committee (1981), too, expressed serious concern about the pattern of drug production in our country. All these efforts by socially conscious organisations and individuals have demonstrated that a large majority of 50,000 drugs and formulations available in our country are hazardous, useless, unnecessary and irrational. Such products not only harm the interests of consumers and inculcate irrational medical practice, but are also causing waste of resources and increasing cost of medical care.

Another example of irrational practice is the indiscriminate use of injections. It would not be an exaggeration to say that our

doctors as well as the public who have been educated by the medical profession, are seized with a peculiar injection culture which is a glaring manifestation of the prevalence of irrational medical practice in our country. In a study of 100 doctors in Bombay city by Uplekar and Rokle (1987) it was found that the injections most commonly used by the general practitioners were antibiotics (46%) and vitamin preparations (24%). In their study the most frequent use of injections for vaccination was mentioned by only 4% of general practitioners. Further, when they interviewed 10 drug distributors supplying drugs to the general practitioners practising in the areas surveyed, they were told that "Dexamethasone injection" was one of three top-selling products.

Without going into details, on the basis of vast and accumulating literature, one can easily say that a growing trend in the medical practice is towards irrational therapeutics, over prescription, unnecessary investigations and unnecessary surgeries.

Reasons for Irrational Practices : Why are doctors resorting to such practice? In the private practice, desire to earn more money is undoubtedly a significant reason. Irrational practice is related to the **supplier induced demands.** But another factor responsible for this state of affairs is also "ignorance". To say that doctors are ignorant of rational medicine may sound contradiction in term, but unfortunately it seems so. In two studies of prescription practices by private general practitioners in Bombay city, Uplekar (1989a, 1989b) found that they had grossly inadequate knowledge of highly prevalent diseases like leprosy and tuberculosis as well as of the standard regimen for their treatment.

In our country there is no system of effective continuing education of doctors engaged in medical practice. Once registered with the Medical Council, the doctor is not required to undergo retraining or examination for renewal of registration. For non-allopathic doctors, the continuing education is non-existent. As a result, there is no effective mechanism to provide correct information to doctors and to orient them to rational medical practice. This lacunae in doctors' continuing education is sought to be filled up by the industry through their medical representatives (MRs). The way the drug industry educates doctors is documented by many health workers (Shatrugna, 1985; A Student Group, 1985; Bal, 1987 etc.). Most of them have argued that such closer relationship between the doctor and the industry is detrimental to the interests of the patient. They have revealed unethical practices like providing drugs free to the doctor in the name of samples, cut-practices, commissions, treating doctors in posh hotels by organising the industry sponsored seminars, offering foreign trips and so on. All these things make doctors ignore cost and rationality of drugs used by them.

There is enough evidence to show that a cost conscious doctor would prefer cost-efficient drugs without harming the patient's interest (Patel, 1981) or a firm policy change like introducing rational drug policy and use of generic names leads to cost-efficient use of rational drugs. This is shown by the Bangla Desh experiences (See Balasubraminiam, 1982 etc.).

Ethics and Law : We need not emphasise again that many of the ills of the medical practice can easily be corrected by better continuing education of doctors and the stringent self-regulation by the Medical Council. However, that the latter has not shown such social responsibility is made evident on numerous occasions. In a recent controversy on the misuse of amniocentesis and other pre-natal tests, the Medical Council did not show any progressive inclination thus forcing the Maharashtra State government to pass legislation to stop the misuse of the pre-natal diagnostic tests. However, in the rest of the country, this blatant anti-female misuse of medical technology is still permitted.

Although not so many malpractice cases are subjected to legal action, there is growing evidence that the media are reporting more cases of malpractice and a few courageous consumers have even taken recourse to court (Desai, 1988). It is not difficult to predict that given the way medicine is practised, malpractice litigations are going to increase.

Private Sector's Influence on the Public Sector

The public sector health care does not merely co-exist with the private sector. Since the private sector is dominant with almost 80% of doctors working in it, the public sector is in many way led by the private sector. This does not need much explanation as it is quite obvious. It is evident in the location of medical colleges, in the content of medical education, in the way Medical Council functions and so on.

The norms of medical practice are therefore set by the private sector. The value system of private sector medical care, namely commercialisation, high technology orientation etc. have come to dominate the practice of medicine. The curative care component of public sector is also greatly influenced by this value system of the private sector. As a result, one witnesses increasing illegal or unofficial private medical practice by government doctors in PHCs and hospitals. There are even agitations by doctors to make their private practice official. It is also not unusual to see government doctor doing private practice, sometimes even using PHCs' medicine for the practice while sitting in the OPD of the PHC.

Although the State is involved in production of drugs, the PHCs, are supplied drugs in inadequate quantity and in an irregular manner. Even at the PHCs, significant number of irrational combination drugs and unnecessary drugs are found. The doctors are found to be giving prescriptions to patients for purchasing

drugs from the market (Jesani, 1989). And we find that the drug industry's medical representatives make visits to the government doctors in the same way and for the same purpose as they do for doctors in the private sector.

In short, the Bhore Committee expected the public sector to lead in the health care development. But in reality, it is being led by the private sector. In many analysis of the public health care the political problems, problems of its orientation etc. are discussed. But very little is done to assess the influence of private sector on it. Some scholars have written that the public sector's malfunctioning is providing a scope for the expansion of the private sector. It is also necessary to assess how the private sector oriented policies of the State and the actual existence of an unnecessarily large big private sector with its dominant value system have contributed to the malfunctioning of the public sector.

CHAPTER FIVE

EXPERIENCES OF DEVELOPED COUNTRIES : A BRIEF OVERVIEW

In Chapter Two, we showed that in the inter-war period, the State's economic functions greatly increased. The welfare States were established in Western Europe in the post-second World War period as it was realised that full employment, social security and provision of services were essential for the growth of the economy and to keep check on the militancy of the masses. However, the State's **direct** involvement in the provision of services, particularly health care services, was not universal. In fact different countries evolved their own particular mix of services provision by the government and the private agencies. But what is universal in all these countries is that the State took active interest in ensuring that a reasonable level of services were provided to most of the people. This intervention of the State, alongwith its intervention in the economy, ensured that the State expenditure showed marked increase as compared to the earlier times.

State Expenditure in Health Care : Just as the high level of State expenditure in general is universal in the developed countries, the State expenditure in the health care sector is also quite high in most of them. Those countries which became centers of classical welfare statism and opted for the public provision of health care services, the State expenditure in health care is found to be quite high. For instance, in four North-West European countries, namely, the UK, Denmark, Finland and Sweden, in 1984, the State financed 89%, 83%, 79% and 91% of the health care expenditure respectively. Thus in these countries, only a small proportion of health care is paid for directly by the patient/consumer or through private insurance (Weiner, 1987). In these four European countries, the health care is not only overwhelmingly financed by the State but also provided chiefly through the public sector. In these countries in 1984 the total health expenditure as the percentage of GNP was 5.9% in the UK, 6.3% in Denmark, 6.6% in Finland and 9.4% in Sweden (Weiner, 1987). In contrast, in the USA there is no national health service and most of the health care is provided through the private sector. The cost of the health care to the nation here is in no way low, but in fact one of the highest as the USA spent 10.7% of GNP on health care in 1984. The growth of health expenditure in the USA is taking place at an alarming rate and it is projected to reach 15% of the GNP by the year 2000 (Winkenwerder and Ball, 1988).

Private provision of health care in the USA does not mean that the State plays no role in the health care services. The State in the USA financed 41% of the health expenditure in 1984. The only difference being that much of the State finances were routed through the private sector to subsidise health care of certain stratas of people. It is argued by some scholars that "the

passage of Medicaid and Medicare by Congress in 1965 brought many previously uninsured people into the market for private health care. Medicaid and Medicare were the cornerstone of the expansion of social-welfare programs in response to the growing militancy of the dispossessed and constituted a real victory for the health of the poor and elderly. However, both programs helped not only the poor and elderly but also the health care industry itself, by dramatically increasing and radically reorienting State spending on health. Government spending which had hitherto been concentrated in relatively small direct grants to public health programs and public hospitals, sky rocketed and was directed to the purchase of care in the private sector" (Himmelstein and Woolhandler, 1984). What is clear from the experience of the USA is that the State expenditure intended for the weaker stratas of the society but channelised through the private sector, could provide a great boost to the growth of the for-profit health care industry. The momentum gained by the private sector through the ensured contribution of the State makes possible its rapid expansion and therefore, the private health care industry in the USA owes a lot to the State for its commanding position.

Not-withstanding various ways in which the health care services are organised in the developed countries, it is clear that without significant State support and enormous State finances, the health care services in those countries would have achieved very little in terms of actual welfare. The role of State finance and State support does not become insignificant in any of the situation prevalent in the developed countries. The political choice made by the US society in 1965 to start Medicaid and Medicare show very clearly that in order to provide the health care to the deprived, in order to cover those not covered and in order to even talk in terms of making health care accessible, the first step to be taken is **to step up State expenditure** in health care. This has a lesson for the underdeveloped countries, that irrespective of the controversy on who should provide health care, or whether the provision through private sector is more beneficial as compared to that through public sector; in either case of making health care accessible to the people, the State expenditure would increase rather than becoming less. The historical experience in none of the developed countries testify that broad coverage by the health care services, either private or public, could be achieved while decreasing the State expenditure in the health care services.

This does not mean that in the developed countries the State support has automatically ensured equal access to the health care for all. The question of equality is altogether different and it is not simply and only related to the health care but also to the overall socio-economic structure. What is important to note however, is that in the developed countries question of access is not due to the virtual absence of services as is the case for a large number of people in the underdeveloped countries.

Accessibility and Cost of Services : How do the public and private health care delivery system deal with the most fundamental problem of health care, namely, making it accessible to all? This means, in order to attain universal accessibility, the health care delivery system must eliminate financial and non-financial barriers to the receipt of care.

In our country the most important problem is the physical access to health center. This highlights the locational problems of health care infrastructure which we have already discussed in Chapter Three. This problem of appropriate geographic location of the health workers, dispensaries and health centers is not fully solved in any country. There are always certain remote areas where occasionally one finds relative lack of services in the best of the delivery systems. However, the **better accessibility** of health care under the national health services can be understood from the fact that in the 1960s and the 1970s, the countries with the NHS were often cited as examples of access-conscious services. Indeed the better access to health care under the NHS was the central argument advanced by the proponents of the NHS in the US in those two decades (Weiner, 1987). Another argument successfully advanced is the **removal of financial barrier** to the receipt of health care under the NHS. In most of the countries with NHS, there is rarely (with an exception of Sweden where a modest payment is needed) any out-of pocket payment required on the part of the patient to get primary care. This is also associated with the fact that in countries with the NHS, except Sweden, in 1984 about 25 to 30% of total health care expenditure was made on primary care. The proportion of such primary care expenditure in the US was only 18% in that year. Further, in the UK 46%, in Denmark 25%, in Finland 25% and in Sweden 23% of all doctors in 1984 worked as General Practitioners or Family Physicians. In comparison, in the US in the same year only 14% of all doctors were involved in such primary care (Weiner, 1984).

The issues of access and cost are the most acute in the private sector health care, and are thus highlighted more in the delivery system of the US. But they have their relevance in other countries too, as certain features like expensive hi-tech medicine, have penetrated most of the advanced countries.

In the US it is found that the for-profit hospitals "tended to be located in affluent suburbs, where the pressure to provide charity care was reduced, and in general they avoided high-cost, low-profit services such as operating outpatient departments and emergency rooms or running teaching programmes" (Ginzberg, 1988). This contention of Ginzberg is based on the fact that in 1985, 60.7% of the acute care beds of the for-profit chains were located in just five States : California, Florida, Lousina, Tennessee and Texas (American Hospital Association, 1987). Many other empirical studies in the USA have shown that proprietary facilities are more likely to locate in areas with high per capita incomes, a limited number of Medicaid patients and broad

insurance coverage. Further studies show that investor-owned facilities are significantly less likely to offer services that are unprofitable but which generate widespread community benefits; and lastly, the proprietary institutions are significantly less likely to offer services to low-income patients at a reduced charge and provide, on average, less uncompensated care (for a brief discussion with review of such several studies, see Schlesinger, Bentkover e.al. 1987). Further, in the same study of the access to health care and the type of hospital, Schlesinger, Bentkover et.al. (1987) found that the growth of for-profit providers will have far-reaching competitive effect on other providers. Their findings indicate that the growth of the for-profit market share from 0 to 50 per cent would induce additional restrictions on access in neighbouring non-profit hospitals of the same magnitude as those found in for-profit hospitals. From their findings, they concluded that assuming that the growth of private health care is likely to continue in the foreseeable future and that competitive pressures are likely to increase as a result of the entry of new providers, purchasers' continued sensitivity to costs, and public policies designed to encourage competition; **each of these trends may be accompanied by restrictions on access to hospital services for low-income patients.**

In a study comparing primary care in four European countries with that in the US, Jonathan Weiner (1987) concluded that there are two major advantages of the public sector health care. "The first of these is the high level of access to primary care services enjoyed by all citizens, without regard to purchasing power. The second advantage is the geographic or community perspective of the system". Weiner believes that intrinsic in the design of the primary care delivery programmes in the European countries with the NHS, is the assumption that no person should be without care, regardless of income or place of residence. However, based on his findings, he feels that the privately controlled American primary care system can make no claim of uniform access to all segments of the population. However, he also found that the Health Maintenance Organisations (HMOs) of the US show high level of access **for those it served.**

In the context of the US when we talk about the high cost of medicine and therefore difficult access to health care for the people from low income groups, we immediately confront the question of minorities like Blacks, Chicanos and others. Mark Schlesinger (1987) in his study on this aspect concluded that "a more competitive health care system will have mixed but predominantly negative effect on less advantaged black Americans".

Similarly, the inequality in health care provision to various stratas of people is also an important issue for the countries with the NHS (see Black Report, 1982). However, such inequalities in health status and health care in those countries are not directly connected to their lack of purchasing power as

the patient is not required to pay for the services at the time of obtaining it.

Rising Cost of Health Care : The rising cost of health care is considered to be the single most serious problem of health care services in the US. The factors like high technology have also made impact on the countries with the NHS and made them to be more conscious about the cost of health care.

In the context of competitive health care market it should be realised and the experiences of the developed countries show that increased competition does not necessarily lead to the lowering of the prices in the health care. In fact in the US, competition has produced an altogether different effect and has raised the cost of health care.

Commercialisation of Health : The health care as a commodity is sold by the health care provider in the market. In the situation of heightened competition it is but natural that the process of selling health care on the market has to be commercialised **in all aspects.** The market in health care can be expanded by enhancing people's dissatisfaction with their health. A myth has to be propagated that good health can be purchased. As Arthur Barsky (1988) put is, "Each producer tries to convince the public that something is dangerously wrong or about to go wrong and that immediate steps must be taken to remedy the situation. An indifferent public is first galvanised into becoming a market of alarmed consumers by constant reminders of myriad threats to health, and then convinced of the need for more and more products and services to protect them".

Medicalisation : Medicalisation of more and more aspects of daily life is a logical corollary of the commercialisation. Minor symptoms, self-limiting short-duration illnesses etc. which were hitherto not considered important diseases and tackled at the household level by simple remedies, are now brought to the doctor with increasing regularity and the doctor, in order to keep up his commercial interest and so-called professional reputation, medicalises those problems by showing that great medical skill is required to treat such problems. In the developed countries, it is estimated that in last fifty years, the mean number of visits to the doctor per person in a year has doubled (Barsky, 1988).

The medicalisation has changed many things. Some "deviant" and "undesirable" forms of behaviour, like alcoholism, drug addiction etc. are now being classified as diseases. The doctors are asked to treat physical conditions which are not diseases, they are, baldness, unattractive features etc. As a result number of cosmetic surgeries has fast increased. Ivan Illich (1975) discusses at length about medicalisation of daily life in his "Medical Nemesis" and therefore, we need not deal with the same at length. In 1986, in an article in the Lancet titled "Body History", he claimed that "in addition to the perception of illness, disability, pain and death, the body percept itself has

become iatrogenic". He elaborates this by saying that "During the 1960s, the medical profession was prominent in determining what the body is and how it ought to feel. During the 1970s it has begun to share with other agents the power to objectify people. From an enterprise that objectifies people as bodies or psyches, a new model has sprung that engenders people who objectify themselves : those who conceive of themselves as "producers" of their bodies".

In short, the process of commercialisation and medicalisation is very important and at the heart of further development in the private sector in health care. There is enough information available to show that they laid foundation for the subsequent emergence of the for-profit corporate medicine in the US (Light, 1986).

The commercialisation and medicalisation are also related to the irrational medical care involving things such as, irrational use of medicine, unnecessary investigations, defensive medicine, unnecessary and even irrational use of other technologies and so on.

Medical Technologies : The role of increasing usage of various technologies and specifically the new hi-tech instruments, in medical care is well documented. In last two decades, a plethora of new diagnostic and treatment devices have been added. Not only have new technologies taken over the essential functions of doctor in medical care but they aid him or her in performing many other functions. The technologies have created even new functions. In the process a rapid division in the medical functions has taken place and each function has been sought to be specialised by assigning the aid of some special, complicated and costly machine or technology.

In the sector of individual private medical practice many new private practitioners with technological speciality are added. Indeed we have come a long way from X-ray clinics to CT scan centres. The proliferation of diagnostic centres run by individuals, institutions or companies has lengthened the route which the patient travels in order to get diagnosed and treated (Jesani, 1987).

In the developed countries, the expansion of clinical laboratories due to introduction of hi-tech machines is phenomenal. Here the increase in the cost is not simply in terms of increased capital investment and the overuse of the equipment. It is also related to the type of machines which are marketed by the companies and how they favour big institutions against the smaller ones. For example, one trend in design and production of chemical analysers has been to increase their loading capacity. This makes the cost of new analysers prohibitive to smaller institutions and thus forces them to send their work to independent, private laboratories. Further, each model is created in such a way that increased number of tests can be

performed simultaneously and this is happening to the extent that the physician no longer has the choice of ordering single tests (Levitt, 1984). Thus, like the fixed dose combination drugs dominating the pharmaceutical market and the industry constantly persuading doctors to use them, in the clinical laboratory business too the doctors are now being persuaded to use or order "fixed combination" of many tests. Obviously, all these play crucial role in cost escalation.

Competing Technologies : Two technologies compete when they are used for the same purpose; when the use of one precludes the use of the other in the same patient; and when there are no data that establish definitively the superiority of one over the other (Petitti, 1986). Thus, many technologies useful for the same purpose compete for capital investment in equipment. For example, the lithotripsy equipment is different; and also having different cost, depending upon whether one requires a machine for percutaneous lithotripsy or for extracorporeal shock-wave lithotripsy. Such competing technologies increase cost not only in the capital investment but also increase cost because each option has space and maintenance requirements. Further, the cost escalation is also due to the need to train personnel to use several different pieces of equipment or to work under several protocols. Similarly, practising physicians may need to undergo costly additional training so that they can use techniques that compete with those they have already mastered (Petitti, 1986).

New Disease Entities : New technologies and their use in lengthening life even in those conditions which were earlier considered "end-stages" of the disease, contribute substantially in nation's bill of the health care. For example, earlier the kidney failure not reversible by treatment was the end of patient's life. However, introduction of dialysis machine and kidney transplantation radically changed the consequences of the kidney failure. In a way, the medical technology created a disease entity called End Stage Renal Disease, a disease that would not exist without the technology (Plough, 1981).

Regulation of Medical Technology : Traditional methods of regulating new technologies are found to be highly inadequate as they do not conform the market needs. Since new technologies are very sophisticated requiring heavy financial input in innovation and production, the industry has no patience to wait for lengthy testing of the technologies. In the present market set-up dominated by strong monopolies, the best way to preserve monopoly is to accelerate technological innovation and consequent rapid introduction of new products in the market. This creates a situation of **permanent technological and product renewal.** This characteristic of the market economy is primarily at the root of continuous introduction of new drugs, devises and hosts of other things, irrespective of actual medical needs and priorities of the people, into medical practice.

The existing technology assessment in the US is such that no

strong barriers are created to the continuous introduction of all kinds of technologies. In fact, in 1980, a conference at the Institute of Medicine concluded that the US lacked a systematic strategy for assessing medical technologies even though the Office of Technology Assessment had a health programme since 1975 (Jennet, 1986). Furthermore, it was found that 98% of the 5000 new devices introduced each year are considered substantially equivalent to existing ones and are therefore exempt from evaluation (Jennet, 1986). Another study of the FDA's regulation of the medical technologies in the US found that data on the safety and effectiveness of the new technologies considered substantially equivalent were hard to get and that under present system several generations of devices are passed off as being substantially equivalent (Kessler, Pape and Sandwall, 1987).

In short such uncontrolled and continuous introduction of all kind of technologies is contributing substantially in increasing the cost of medical care at such a fast rate (For study of the cost escalatory effect of technology in the US hospitals, see Russell, 1979).

The Burden of Malpractice Litigations : To this should be added, in the market economy model, the staggering increase in the number of malpractice litigations. The doctors in the US pay a very high premium for the malpractice insurance. In any case, the time and money spent in litigations and also the consequent increase in defensive medical practices, all act strongly to increase the cost of medical care. The situation in the countries with the NHS is not so bad and the malpractice claims do not make a serious impact on the NHS resources (Quam, Fenn, Dingwall, 1987).

We have presented above certain key factors contributing to the rising cost of medical care. The list of course is not exhaustive because lot of work has been done on this issue and a bulk of literature is not scanned by us due to lack of time and space. What we have done is to identify certain broader issues like commercialisation, medicalisation, corporatisation, use of expensive technologies and so on, which are so fundamental to the rising cost of the health care that the cost-containment cannot be successfully attempted without tackling them. In any case it should be noted that these factors are at the root of certain commercialised irrational use and over-use of medicine. In the developed countries, though, due to better internal regulation of the profession and also the pressure of malpractice litigations, the irrational use of medicine is made out to be less blatant than what we see in our country. However, studies have shown that the doctors working in the market set up tend to go for surgical intervention more than doctors working in the public sector set up. It is interesting to note that a formal attempt in the US to limit what was considered to be unnecessary surgery followed a Congressnal Subcommittee estimate that in 1974, 2-4 million unnecessary operations had been performed at a cost of 4 billion dollars and of nearly 12,000 deaths (Jennett, 1986: 100).

It is well known that where surgery is a chargeable item of service there is a financial incentive for surgeons to recommend operations. In her study of technology use in hospitals, Louise Russell (1979) argues that the growth of third party payment system has also diminished cost consciousness amongst the health care providers and the patients leading to excessive usage of the technology.

Cost Containment : The rising cost of medical care in the market situation is so great that now there is a genuine worry among the policy makers about its negative effect on the system as a whole. This is quite natural because if regaining normal labour and intellectual power for an average person were to become so expensive, the system would come under great strain. Most of the reviews of the cost containment strategies used in the market set-up in the US suggest that they are hardly addressed to the basic factors causing increase in cost. Most of the measures adopted are about manipulating the financial control in order to cut costs. In the prevailing situation of continued rise in cost in the US, it is natural that most of the studies show little evidence that cost containment strategies have been very effective (Newman, Elliott et.al., 1979). Of late the HMOs have started using financial incentives and disincentives to make physicians cost conscious. In fact, in the US the policy makers are now-a-days showing more concern on policies which place physicians at financial risk for deficits in the referral funds and which calculate penalties on the basis of their individual actions. No comprehensive and conclusive study on the effectivity of such strategy in containing cost without negatively affecting quality of medical care is available as yet. However, a study by Hillman, Pauly and Kerstein (1989) suggest that such strategies seem to have an effect in changing the doctor's behaviour towards individual patients. Their findings suggests that such cost consciousness seem to decrease the number of primary care visits by patients to doctors, as the doctors in order to save, scheduled fewer visits by the patients. But such cost consciousness does not seem to affect the rate of hospitalisation. In a study done earlier, Hillman (1987) had found that certain financial incentives in the HMOs, especially when used in combination, suggest conflict of interest that may influence physician's behaviour and adversely affect the quality of care. However, all these studies are not conclusive. Thus attention is focused more on the moral dilemmas of doctors who implement cost containment strategies.

As was expected, the for-profit institutions' curbs on the physicians' behaviour has raised many issues. Fundamental to those issues is the question of the character and objectives of those institutions. Arnold Relman (1988) argues that "organisations that place a higher priority on profits than quality of service may influence the professional decisions of their physician employees adversely. When fee-for-service is the basis of payment, management may pressure the medical staff to run up the bill. Conversely, when payment is per capita,

management may try to constrain the use of even beneficial services". Kralewski, Dowd et.al. (1987) have also expressed great concern about the controls being placed on physicians' practices by the HMOs, preferred-provider organisations, third-party insurance plans and in some cases, their own group practices.

Since the cost-containment plans essentially implement rationing of health care into practice, the physicians acquire controversial role of "gate-keepers". "Because the rationale for developing the gate-keeper function is one of financial efficiency, various economic setting affect the mix of clinical and financial judgements and pose ethical problems" (Reagan, 1987). Most of the writers admit that there is no escaping from the situation, they also feel strongly that the issue of financial efficiency in the context of organisation's goal to make profit, would greatly curtail their professional autonomy.

Rationing of Health Care : In a thought provoking article Michael Reagan (1988) argues that a distinction should be made between the rationing and the financial allocation. He makes it clear that **financial allocation** in health is largely a "Macro-Level" decision and since such decisions are taken in the larger public interest, they have been better accepted. He cites examples of allocation of a fixed budget for health care in the UK. Further, even at the "macro level' in certain decisions the allocation and the rationing come together. As an example he cites the restriction on dialysis machines or CAT scanners in the UK. The **rationing**, on the other hand largely involves "micro-level" decision making. He defines the rationing as a system of deliberate choices about the sharing of health care resources among persons (i.e. who gets what care and in what order of priority) on grounds that go beyond an individual patient's clinically defined needs, the criteria specially include both comparative medical needs and social equity". The rationing of health care thus defined makes it clear that it is (a) not same as simply reducing the volume of services (b) it is also not a process of making choices by deduction from economic decisions rules, such as cost-benefit analysis or risk stratification, and (c) it is also not defining as person's eligibility to receive medical care on the basis of his or her financial position in the society.

In essence, this argument on the rationing is well accepted within the medical practice, namely that when choice is to be made on the use of limited resources, the decision should be based on the genuine medical needs and the social equity; rather than on one's capacity to pay. This method of rationing, found in the NHS of the UK, is a product of the unavailability of resources and a more or less implicit understanding among physicians about the appropriate limits of care (Mechanic, 1985).

However, the process of rationing health care in the competitive market could take quite different course. Here in addition to

the broad rationing through the price mechanism, the rationing takes place depending on the pressure of cost-containment methods used, the methods of financial control adopted, the fear of malpractice litigations and so on. David Mechanic (1985) feels that in the market set-up of the US, the rationing will occur primarily in the area of amenities, in the intensity of diagnostic and laboratory investigations and in the discretionary use of hospitals and surgical interventions. He feels that it is less likely that rationing will occur by withholding or significantly slowing the use of new technologies. He believes that in the present circumstances the US health care system "as a whole is more likely to evolve by muddling through and by individual groups taking advantage of new market opportunities and incentives, than by broad efforts to rationalise and reform the system".

The Crisis and the Alternatives : There is a growing body of literature describing the present situation in the US health services as the crisis situation. Many authors like Illich (1975), Navarro (1976) and others have analysed various aspects of this crisis. Crane and Legay (1979) have classified the themes dealt within the 'crisis' literature in three broad categories. The first one points at the issue of restricted access to quality health care. This includes the issues like cost of medical care, distribution of quality services and quantity of health care services. The second category is on the Creation and Extension of Medical Dependency. This includes issues like medicine as an agent of social control, exploitation of subjects and de-humanisation of subjects. The third category examines the issue of modern medicine's inadequate world view. This raises fundamental issues like the rationality of modern health care, legitimacy and necessity of health care, conflicts in the social status of health care, resistance to social innovation and quality of health care.

These sociological analysis of the crisis in the US health care point to deeper structural problems and the alternatives provided are quite radical. However, many of them do advocate national health services for the US to solve the immediate problems in the health care system.

Lessons of the Canadian Experiment : The Canadian experiment is undoubtedly exerting great influence on the medical profession in the US. This is because before 1971, the Canadian health care system was quite identical to the American one, and the health care costs consumed a share of national income that was virtually identical in both countries and was rising steadily. However, in 1971, Canada introduced NHS while the US decided to continue with its predominantly private sector health care model. After 1971, we find that the health care cost as percentage of GNP has remained stable in Canada whereas that has continued to rise in the US. This has happened in Canada along with the universality of health care coverage (without user charges) which eliminates the problems of uncompensated care, individual burdens of

catastrophic illness and uninsured populations (Evans, Lomas et.al., 1989). Further, it is pointed out that the process of cost control which inevitably involves certain amount of conflict of interest, takes place in the countries with NHS as a part of the political processes. That makes the conflict of interest explicit and thus helping the community to express its collective opinion in a more articular manner. The process of cost control in the market place, on the other hand, tries to hide and diffuse the conflict of interests. It is also suggested that the cost control through the political process results in less intrusion on the professional autonomy of the individual physician than is occuring in the US (Evans, Lomas et.al., 1989).

Given such crucial issues as the accessibility, costs, methods of financing, professional autonomy etc. involved in the Canadian experiment, its relevance is not limited only to the US or to the developed countries but it is equally relevant to even underdeveloped countries.

For a more Rational System : In the early 1970, the debate on the national health service in the US had acquired some focus and importance. But later this subject was almost entirely dropped from the agenda. The present crisis in the health care has reopened this pandora's box. The debate has begun with the plea for a more organised, rational and cheaper health care.

Enthoven and Kronik (1989) in their proposed alternative plan for the US say categorically that the present "health care economy is a paradox of excess and deprivation..... to an increasing degree the present financing system is inflationary, unfair and wasteful". Their alternative plan, titled "A Consumer Choice Health Plan for the 1990s" advoc es universal health insurance with the elements of managed competition, informed cost-conscious consumer choice and rewards for providers who deliver high-quality care economically.

To Sum Up : What is clear from the above discussion on the experiences of health car provision in the developed countries, is that the countries with better Planned National Health Services have shown better performance by actually achieving social goals of universal provision of health care services. Although these countries also face the crisis of providing more resources to the health care system and attempts like the one in the UK by the Thatcher government have been made to begin the process of dismantling the NHS in order to resolve the crisis, this has resulted in great public resistance and opposition even from supporters of the government. In the UK, the Thatcher Government's "reforms" are being countered not only by the medical profession but also by the people in general showing that the NHS has struck deeper social and political roots than one would have ever thought of.

In the US, which has the private sector health care system, on the other hand the social objectives of universal access to

quality health care are subordinated to the needs of the market. The experiences of this richest country in the world have shown that its model of health care has, despite the existence of competition, failed to fulfill the social objectives of welfare. And this is happening despite more than two fifth of the health care expenditure is financed by the State.

CHAPTER SIX

EMERGING ISSUES : STATE, MARKET AND PRIVATISATION

Providing health care services to the mass of people is now considered to be an essential function of all societies. The historical as well as contemporary experiences in various ways by which the quality health care services in optimum amount is made available to people raise very complex issues. No country with **predominant market economy** has adopted a single method of health care provision. In each country a mix of public and private provision of health care services has emerged and the specific relationship between the two is determined by the historic evolution of the health care services and economy; the pressure exerted by the deprived stratas and the political orientation of the leadership; the health care and economic resources at the disposal of the society and so on.

However, when we argue about the mix of public and private provisions of health care services, it does not mean that a political choice about which method will be given a place of importance is not made. In fact, it will be impossible to understand the strength and the weakness of various methods of health care provision without recognising that a broad political choice of method has been made in almost all countries. It is true that in the overall framework of the political choice made, lots of variation, pragmatic amalgamation of method in practice, changes in prioritisation etc. have been allowed. Therefore all pragmatic changes in the health care policies should be viewed in the context of larger political choice made and of the historical tendencies in the evolution of health care structure.

For illustration, let us compare health care services in the UK and the USA. We have earlier discussed their strengths and weaknesses. But both countries have developed market economies. In a superficial way one can say that USA has a market model and the UK has a public provision model for the health care delivery.

These models have historically evolved and they also tell us about the political processes underway in both countries. Despite larger political choices made by both countries, these models do not adopt exclusive methods. The US market model owes a lot to the State support. In fact it would collapse or say go into severe crisis if the State support were withdrawn. In the UK, on the other hand, the public provision model does not banish the private sector. In fact, the private sector has experienced very fast growth in the last one decade (Higgins, 1988). In the NHS, the individual practitioners are not abolished. In fact, such doctors continue to be private practitioners but they are paid for the services provided to the people, by the State. And such General Practitioners are backbone of the NHS and provide highly essential primary care is recognised by all.

Thus, in order to identify relevant issues in the debate on the health care provision, we are inclined to accept Max Price's (1988) argument that "it is necessary analytically to recognize three distinct components in the economic organisation of any particular health service. These components are : (1) Methods of financing health service, i.e. how funds are raised to pay for health services, (2) Methods of remuneration of providers; and (3) Patterns of ownership of the health services".

Economic Organisation of Health Care Services : Max Price (1988) has exhaustively reviewed the components in the economic organisation of health care and collate various options tried out internationally. We reproduce below an alternative frame-work presented by him in a tabulated form. In the table, firstly, the economic organisation has been divided into its three component parts. Secondly, within each component a number of possible methods are identified. The methods within any component are not mutually exclusive, and frequently occur together in the same organisational form. Thirdly, on the right hand side of the table, an attempt is made to indicate the links between the categories used and conventional categories. And fourthly, also in the right hand column are mentioned the institutional forms which usually manifest in the particular methods of financing or remuneration or patterns of ownership (Price, 1988).

When these three components of economic organisation of health care services are examined in India, certain important issues emerge :

Firstly, although most of the methods in each component are tried out in our country, their mix and the effect produced are of serious concern. The financing component in India shows that the public financing of health expenditure is a very small component as private or out of pocket expenditure by the households constitute over 80% (see Chapter Three). This makes user charges as the predominant method of financing in our country. Further, private health insurance is quite insignificant and whatever is there - like Mediclaim of United India Insurance and Birthright Policy of New India Insurance (for treating birth defects) etc. are largely for tertiary care and contribute in escalating the cost of medical care.

Secondly, the reimbursement of providers in our country is predominantly by fee-for-service methods. The capitation fee method is quite negligible and found only in ESI, some public sector companies etc. The salaried staff is the predominant method in the public sector health care but inadequate supplies (shortage of drugs) and corruption (private practice and bribes) in the public sector add to the fee for service method.

Thhirdly, the ownership pattern is discussed in Chapter Three and we find the though majority of hospitals and beds are in the public sector, the private sector propped up by the user charges and the fee-for-services methods, is fast expanding. Since 80%

Table : Three Components in Economic Organisation of Health Services and Available Options

Components of Health Service Organisation and Options with each Component	Conventional categories and Institutional form usually taken
A. METHODS OF FINANCING	
Public Methods of Financing :	
Taxes - General	Income, company, property taxes
- Sales tax, import/export duties	Sales, tax, tariffs and duties
- Charging out costs of those who genrate them	Motor vehicle licences and compulsory third party insurance
	Taxes on tobacco, alcohol
	Workmen's compensation contribution from employers
Deficit financing	Deficit financing and foreign loans
Foreign Aid Grants (bilateral/multilateral)	Foreign Aid Grants (bilateral/multilateral)
Lotteries and betting	Lotteries and betting
Public, Quasi-public or Private Financing Methods :	
Employer and employee contributions (other than general taxes)	Direct provision of payment for health services by employer
	Payroll taxes
	- National health insurance
	- Social security, compulsory health insurance
	- Private health insurance
	Charges related to generation of costs e.g. workmen's compensation
Private Methods of Financing :	
Charitable contributions	Frequently from wealthy families, firms, religious groups
Private health insurance	Private health insurance
	Direct household expenditure
User charges	Direct household expenditure - for treatment and drug etc.
	Co-payments - Proportion of total costs, deductibles, excess above ceilings, for excluded benefits

B. REIMBURSEMENT OF PROVIDERS

Fee-for-service	Private practice "Indirect" social security (e.g. as found commonly in Western Europe) Private health insurance Direct household expenditure
Capitation/pre-payment fees	Health maintenance organisations National Health Service "contract arrangements" with GPs (e.g. Britain) Community based/cooperative financing (e.g. Brigade level health care, China)
Salaried/budget allocation	Government provided health services "Direct" social security systems (e.g. as found commonly in Latin America) Employer provided health srvices
Other e.g. bonus systems, merit award	

C. PATTERNS OF OWNERSHIP

Predominantly public owned health service (other sectors very small)	e.g. National Health Service (UK), small private sector, small or no quasi-public sector.
Multiple sector, Many private providers as well as public and quasi-public sectors	Public sector as well as one or more social security schemes and/or employer providers and/or self-employed practitioners.
Community owned health services	Community financing*

(*Note : Community financing and self-help do not fit easily into any system of classification because it encompasses so diverse a range of options of health services organisation, e.g. contribution in kind, such as labour, materials, agricultural produce, user charges for drugs and services; household or communal contributions to pay the wages of health worker as a part of risk sharing arrangement (Stinson W. "Community Financing of Primary Health Care", WashingtonDC : Primary Health Care Issues, Series 1, No. 4, American Public Health Association). The main virtue of considering community financing as an entity is that it draws attention to the use of non-monetary resources, local resources of finance that are often overlooked, and other factors that may be important for the success of project such as community participation. Although it has recently become the focus of much attention as a means of tapping resources in poor communities for health and health related services, the particular strategies considered can be fitted into one of the methods in the left hand column of the table and can be similar analysed. Some forms of community financing may be considered to be unique in their pattern of ownership - viz. where services are owned by the community, as opposed to private or public (State) ownership). (This note by Max Price, 1988).

of doctors are in the private sector and the corporate business is taking more interest in the health care provision, this expansion of private sector is bound to increase unless the State puts some control over it. Thus, though the Bhore Committee (1946) recommended predominant public owned health services, the development since independence has brought about multiple sector wherein the private providers fully dominate general practice whereas in the institutional care, the public sector growth has slackened while that of private sector is very fast.

Health Care as a Commodity : From the above discussion it is clear that in our country the private methods of financing, reimbursement to providers and provision of health care are highly dominant. Not only that, since user charges or fee-for-service is the predominant method of financing, the market in health care is given unrestrained scope to operate. Obviously we are here making an analytical distinction between the private provision of health care and market. For, as Max Price (1988) has argued, the existence of private practice in medicine does not automatically lead to certain problems like perverse incentives (irrational care, unnecessary investigations, surgeries etc.), inequity in provision of care, and maldistribution of doctors.

Now, what happens when health care is provided on the market? We know that the health being a state of well being of the body as well as the mind, it is not tradeable. In the achievement of health, the health care plays an important role but not a central role. The **health care**, however, is tradeable. In a market situation, thus, the health care becomes a commodity. For a exchange to take place on the market, the demand of health care from the consumer is essential. That is why, in the market situation demand of health care is talked about but the needs are rarely mentioned. The demand for obvious reasons, is chiefly of curative care. From this it follows that in a society where private practice in unrestrained market dominates, the health care provision is also dominated by the curative orientation. Further, the planning process in the market situation shows major pre-occupation with the demand and not with the need of the people. For in order to estimate needs and to orient planning to those needs, the application of sciences of epidemiology and social epidemiology (see Segall, 1983); and social cost-benefit analysis in resources allocation become indispensible.

When the exchange on the market takes place, the neo-classical demand theory (expected utility theory) says that, the rational and the sovereign consumer obtains full utility gains or benefits. The assumption is that such consumer is informed, is able to judge the cost, is prepared to bear the cost, is able to judge benefit of the consumption (and also actually obtains those benefits) and lastly, is able to choose whether, if so how much, of what to consume. But the health care is a different kind of commodity. Many scholars have argued that it is so different that the application of the expected utility theory is

potentially less valid (McGuire, Handerson, Money, 1988: 38). There are many reasons for such thing to happen :

Firstly, the rational and informed consumer of health care is more an ideal than real. The health care is heterogenous as well as an intermediate commodity. It is not consumed for itself. It is people's perception of what health is or should be determines the consumption of health care. As a result, for the health care market to expand (i.e. for increasing demand), the people are educated about health in such a way that they demand more and more health care (Illich, 1975, Winkenwerder and Ball, 1988, Barsky, 1988). Thus, an informed consumer is not necessarily having rational perception of health.

Secondly, in the health care market, the supplier is an important determinant of demand. This is so manifest in the health care that normal supply and demand separation can not be maintained. Although the **supplier induced demand** hypothesis is not conclusively and empirically verified (many methodological problems), it emerges from many studies that the increased supply of health care providers, instead of lowering demand, has normally increased it by increased number of surgeries, drug consumption etc. (Auster and Oaxaca, 1981, Green, 1988, Fuchs, 1978).

Thirdly, in the health care, the process utility often occupies more important position than the outcome utility. The process is related to decision making, risk bearing and equity. This is so because while making decision, the uncertainties and the risks in outcome are possible or have occurred. Added to this is the risk of iatrogenesis. Thus, there is no guarantee that consumption would automatically ensure actual utility gains. In this situation, the consumer tends to off-load responsibility of decision making onto the doctor who has to bear the moral burden of decision.

Lastly, there are problems with the basic assumptions of the neo-classical **economic theory** in general and many radical scholars have critiqued them at length (Green and Nore, 1977). However, we need not go into details as we have no scope to go into details of economic debates in general.

In short, now it is widely accepted that **market failure** is very common in the health care. The efforts at injecting competition in the health care market from outside have inevitably caused problems for the medical professionals and the consumers alike. Such efforts have also tried to diminish doctor's professional autonomy (Lee and Etheredge, 1989). In any case, problems with the functioning of health care market are such that even the ardent supporters of free market are, more-often-than-not, forced to invite or advocate government regulations on the market (Kinzer, 1988).

These effects of market on the health care services are very

evident in India, too, but so far no initiative to correct them through regulation has come from the government. This is undoubtedly diminishing people's access to health care, people are getting more irrational care than earlier times and the cost of health care is sky-rocketing. It is in this context the trend towards privatisation has made appearance.

Debate on Privatisation : The worldwide trend for privatisation has intensified debate on it. Howard Vane and Terry Caslin (1987) in their book "Currrent Controversies in Economics", talk in terms of "Privatisation Programme" rather than simple "Privatisation". They identify three aspects of privatisation programme in the conservative government"s supply-side policies in the UK. They are : "(1) the sale of publicly owned assets to the private sector **(de-nationalisation)**; (2) the franchising to private contractors of the production of **(State-financed)** good and services previously produced in the public sector **(contracting out)**; and (3) removing various restrictions on competition previously given to statutory monopolies **(deregulation)**" (ibid: 71). Y. Venugopal Reddy (1988a) says that "in the braodest sense, the word is used to describe any rollback of State (or government) in the lives and activities of citizens, and any activity strengthening the role of markets". In another paper he (Reddy, 1989b) states that when privatisation is referred to "micro-privatisation" it is "defined to cover measures of enhancing competition within public enterprises in addition to the standard connotation of transfer of ownership and control from public to private sector" (also see Sankar and Reddy, 1990). But such broad definition of privatisation is disputed by scholars. For instance, Ramaswamy R. Iyer (1989) in his review of T.L. Sankar and U. Venugopal Reddy's (1989) edited book on privatisation, says that it is erroneous to use the term "privatisation" in a much wider sense to cover economic liberalisation in general. He pleads that there certainly are some links between liberalisation and privatisation, but the two are not identical. He believes that the privatisation "is a kind of antonym to the familiar term 'nationalisation'. An advocacy of privatisation usually aims at a change of ownership. If necessary, this narrow meaning could be slightly extended to include cases of transfer of management without the transfer of ownership and cases of contracting out of certain services". In his debate with Sankar and Reddy he further suggests that general "rollback" of the State should be explained in three distinct and separate categories, namely (i) privatisation (ii) liberalisation and (iii) deregulation (Iyer, 1990). Samuel Paul (1988), on the other hand, extends the scope of privatisation activities by saying that "all actions leading to a substitution of private for public provision of goods and services fall within the purview of privatisation".

The debate on privatisation is indeed going to increase. Trends of economic changes worldwide and increasing strength of pro-market, pro-private sector ideologies (neo-liberalism) are going to bring this issue at centre-stage again and again. This will

naturally produce terminological modifications and innovations. However, what is important to understand is that systems of ownership, control, restriction and regulation, though distinct from each other, do not exist independent of each other. Any change in one system invariably produces corresponding reaction in the other systems. Thus the nature of ownership and nature of regulation make sense only when seen in the social context and in relationship with each other. For instance, the NHS in the UK has not "nationalised" medical practitioners. They remain private individual practitioners who have entered into a contract with the NHS. Similarly in the US, the practitioners enter into contract with the State to receive funds to treat certain stratas of people. Yet one can hardly call the US and the UK systems identical, for the simple reason that the character of relationship between financing, ownership and regulation is different and the same is articulated in different context.

Thus the issue of privatisation must be examined in the framework of overall economic organisation of health care services.

Problems with Privatisation Arguments : All arguments for and against privatisation are coloured by the ideological standpoint of the person making them. This indeed is the case simply because the extent to which State should involve in the economy and the services is not simply determined by the considerations of economics but of the politics, too. The relative strength of various stratas conflicting for obtaining better and bigger share of the state finances is reflected in the political processes. The rise of neo-right tendencies in the government power in the USA and the UK have influenced policies in most of developed countries. The support provided by the intellectuals to the welfare state has been shattered. The achievements of welfare state are being decried (Harris, 1987). In the welfare state, the welfare economics had greatly contributed in concentrating economists' attention on increasing the size of the national cake within the existing market system. It had focussed attention on the question of social costs and benefits of resource allocation (Brown, 1971).

Pro-privatisation theories are shifting focus to the market and the private sector. Some of those arguments and problems with those arguments are summarised below :

(1) It is argued that the increased expenditure by other sectors (private individuals, medical schemes etc.) would release public expenditure for other uses. This argument is also a basis for those who believe that charging fee for services from patients in Government hospital will decrease the burden on the State and our health care institutions will be better maintained. In Maharashtra, such scheme was in operation for about six months, but it was aborted by a court injection against it. That six month period is very important for researchers to study and understand whether increased income from private sources really led to resource allocation by the State to other socially

important health care programmes. A study in this area should be undertaken at the earliest because delay might result into a loss of such valuable data.

But there is enough evidence to show that the financial savings in one area does not necessarily increase finances for the socially important programmes. Himmelstein Woolhandler and Bor (1988), in their study of actual patterns of resource allocation in the US found that it is difficult to sustain the central assumption of the Cost Effectiveness Analysis, namely, that the funds denied to inefficient services will be diverted to more efficient ones. They have shown after analysing data that such assumption ignores the political realities constraining health resource allocation. Moreover, the shifting of burden from the State to individual for financing health care does not mean that the public sector subsidies (like tax concessions, subsidies to medical educations, loans and grants etc.) to the private sector will be withdrawn (Price, 1988).

(2) It is also argued that only private provision of services will be able to raise funds from private sources. Fee-for-service method of remuneration to the health care provider is given more importance for this reason. There are two problems in this argument. Firstly, in the fee-for-service method, the fund is raised from those who have less means to pay and their condition of distress will be exploited further making them poorer. In our country when it is officially accepted that more than 40% of our people live below poverty line, this method is morally as well as politically a bad strategy. Secondly, it is assumed that only private providers can raise funds from private sources, the State's capacity to raise funds is ignored. In fact, a socially oriented policy of the State not only can raise funds, but can also raise from those who have higher income. Such policy can also bring about redistribution of income and can partially correct the problem of maldistribution of medical humanpower. For instance, extra tax can be levied from doctors who join private sector.

(3) Contracting and leasing out part of services are also advanced for better efficiency and management of services. Since this has been the dominant mode of privatisation, some studies on it are available. Kate Ascher's (1987) study on contracting out public services in the UK concludes that it works "most smoothly in non-political environments". While noting that it is more "effective when it arise naturally in response to local needs", Ascher suggests that "centralised policy initiatives are unlikely to offer comprehensive answers to local problems". E.S. Savas's book (1987) on privatisation, on the other hand, advocates privatisation very forcefully. However, Savas seems to be highly preoccupied with the financial efficiency in the contracting out methods, and does not go into the broader social issue.

In India, though contracting out by the public sector is highly prevalent, no good study on the subject is available. In the

health care sector, the contracting out is prevalent in building construction, certain functions of hospitals like laundry and catering, but no study on them is available. Some State governments have talked about contracting out PHCs, some wards of the hospital or even complete hospital, but no information on the extent to which such policy is implemented and its effect on the services is available.

(4) The issues of managerial and financial efficiency are also raised in support of contracting out. However, no data comparing working of the public health care institutions with the private institutions are available. It is difficult to accept arguments on efficiency without having concrete proofs to verify them.

CHAPTER SEVEN

CONCLUSION

Can Privatisation Solve our Health Care Problem? : In our country the underdevelopment of public health care services in the rural area is the biggest problem (Duggal, 1988). The problems of maldistribution of health humanpower and health care facilities are directly related to this underdevelopment. As a result, common people's access to health care services cannot be ensured without establishing health care facilities closer to poor people and without making it available free. We have shown that since independence the private sector in health care has developed without any stringent control and today it has become dominant. There is no evidence that private sector and market mechanism have shown access-consciousness and brought about redistribution of services. The rationality of medical practice in the private sector and its social effectiveness are also highly doubtful.

From all information available on the health care sector it is highly doubtful that continued expansion of health care market would do any good to people's health status. The extension of health care market in the public sector would likewise be detrimental rather than beneficial. The issue of involving private sector in provision of health care while the State keeping control with it, is an unexplored area. However, it seems that private sector involvement even under the State control would not provide desired result because given the health care priority of our people, such involvement of private sector would require it to pursue non-market orientation. In such a state of affairs, any policy venture in affecting privatisation will be highly adventurous.

APPENDIX I

TABLE 1 : MEDICAL AND NURSING HUMANPOWER IN INDIA (1952-87)

REFERENCE YEARS	DOCTORS						DENTISTS	PARAMEDICS		
	Allopaths	Homeopaths	Ayurveds	Sidha	Unani	Total		Nurses	Midwives	Total
1952	65370	NA	NA	NA	NA	-	3291	17989	NA	-
1956	76904	NA	NA	NA	NA	-	3003	24724	NA	-
1961	83756	27468	73382	NA	NA	184606	3582	35584	51194$	86778
1966	103184	NA	NA	NA	NA	-	4374	57621	NA	-
1969	128584	110514	155828	1543	24530	420999	5182	69937	NA	-
1971	151129	NA	NA	NA	NA	-	5512	80620	80159	160779
1974	190838	145434	223109	18128	30400	607909	6647	98403	100554	139930
1979	249752	112638	225477	18093	25988	631948	7518	139825	130382	198957
1981	268712	115710	233824	18357	28737	665340	8648	154230	144820	270207
1984	297228	123852	251071	11352	28382	711885	8725	170888	168493	339381
1985	306966	123852	251071	11352	28382	721623	9598	197735	171590	369325
1986	319254	131091	272800	11581	28711	763437	9725	207430	185240	392670
1987	330755	NA	NA	NA	NA	-	9750	NA	NA	-

Source : Health Statistics of India, CBHI, GOI relevant years.

Notes : NA = Not available.
$ = Includes both midwives and health visitors.

TABLE 2 : RURAL-URBAN DISTRIBUTION OF MEDICAL HUMANPOWER IN INDIA

REFERENCE YEARS		TOTAL	ALLOPATHS	DENTISTS	HOMEOPATHS	AYURVEDS	UNANI	ALL OTHERS
1961	R	119969	19187	1122	16185	45112	-	38363
		(49.6)	(29.5)	(20.3)	(52.4)	(61.8)		(54.3)
	U	121533	45837	4407	11075	27875	-	32339
		(50.3)	(70.5)	(99.7)	(40.6)	(38.2)		(45.7)
	T	241502	65024	5529	27260	72987	-	70702
		(100)	(100)	(100)	(100)	(100)		(100)
1971	R	129896	49846	1333	23527	36871	4110	14209
		(48.8)	(39.4)	(22.8)	(61.2)	(62.6)	(52.4)	(49.6)
	U	136083	76507	4507	14917	21994	3736	14420
		(51.2)	(60.6)	(77.2)	(38.8)	(37.4)	(47.6)	(50.4)
	T	265979	126353	5842	38444	58865	7846	28629
		(100)	(100)	(100)	(100)	(100)	(100)	(100)
1981	R	152047	53407	1471	31916	36503	2600	26145
		(41.2)	(27.2)	(18.5)	(63.7)	(57.3)	(38.8)	(59.7)
	U	216818	143147	6493	18188	27211	4097	17682
		(58.8)	(72.8)	(81.5)	(36.3)	(42.7)	(61.2)	(40.3)
	T	368860	196554	7964	50104	63714	6697	43827
		(100)	(100)	(100)	(100)	(100)	(100)	(100)

Source : Census 1961, 1971, 1981, GOI.

Notes : All others denotes data on Physicians and Surgeons (Other categories not covered separately).
R = Rural; U = Urban; T = Total
Figures in parentheses are percentages.
Unani practitioners were not coveredseparately by the 1961 Census.
Sidha medical practitioners were not covered by the census.

TABLE 3 : RURAL-URBAN DISTRIBUTION OF NURSES AND OTHER PARAMEDICAL HUMANPOWER IN INDIA

REFERENCE YEARS		TOTAL	NURSES	MIDWIVES & HEALTH VISITORS	OTHER HEALTH WORKERS*
1961	R	11657	29098	33980	48579
		(47.5)	(38.2)	(66.4)	(45.2)
	U	123141	47111	17214	58816
		(52.5)	(61.8)	(33.6)	(54.8)
	T	234798	76209	51194	107395
		(100)	(100)	(100)	(100)
1971	R	109181	31711	23714	53756
		(39.3)	(30.6)	(65.3)	(39.0)
	U	168569	71899	12606	84064
		(60.7)	(69.4)	(34.7)	(61.0)
	T	277750	103610	36320	137820
		(100)	(100)	(100)	(100)
1981	R	193049	52275	29705	111069
		(43.1)	(31.3)	(59.9)	(48.1)
	U	254956	114913	19874	120169
		(56.9)	(68.7)	(40.1)	(51.9)
	T	448005	167188	49579	231238
		(100)	(100)	(100)	(100)

Source : Census 1961, 1971, 1981.

Notes : R = Rural; U = Urban; T = Total.
* Includes other nursing, sanitary and medical and health technicians.
Figures in parentheses are percentages.

TABLE 4 : SECTORAL EMPLOYMENT OF DOCTORS IN INDIA

YEARS	GOVERNMENT SERVICE	PRIVATE SECTOR	TOTAL
1942-43	13000 (27.4)	34400 (72.6)	47400[a] (100)
1963-64	39687 (39.6)	60502 (60.4)	100189[b] (100)
1978-79	69137 (29.3)	166494 (70.6)	235631[c] (100)
1984-85	81030 (27.4)	214799 (72.6)	295829[c] (100)
1986-87	88105 (26.6)	242650 (73.4)	330755[c] (100)

Sources : a) Report of the Health Survey and Development Committee (Bhore Committee), 1943, Vol. I, pg. 13.
b) IAMR-NIHAE "Stock of Allopathic doctors in India", 1966, pg. 71-72.
c) Health Statistics of India - 1979, CBHI, GOI. Health Information of India - 1985, 1988, CBHI, GOI.

TABLE 5 : MEDICAL EDUCATION INFRASTRUCTURE AS ON APRIL 1, 1986
(DOCTORS OF INDIAN SYSTEMS OF MEDICINE AND HOMEOPATHY)*

	MEDICAL COLLEGES			ADMISSION CAPACITY			OUTTURN (1985)
	Government	Private	Total	Government	Private	Total	TOTAL
Ayurveda	44	54	98	1716	2166	3882	1813
	(45.0)	(55.0)	(100)	(44.2)	(55.8)	(100)	
Unani	6	11	17	256	420	576	539
	(35.3)	(64.7)	(100)	(44.4)	(55.6)	(100)	
Siddha	2	-	2	150	-	150	49
	(100)		(100)	(100)		(100)	
Homeopathy	26	79	105	1318	4595	5913	1769
	(24.8)	(75.2)	(100)	(22.3)	(77.7)	(100)	
Total	78	144	222	3440	7181	10521	3970
	(35.1)	(64.9)	(100)	(32.7)	(67.3)	(100)	

Source : Compiled from "Indian Systems of Medicine and Homeopathy in India : 1986" published by Planning and Evaluation cell of the Ministry of Health and Family Welfare, New Delhi.

* The data are incomplete due to non-reporting by many states and institutions.

TABLE 6 : MEDICAL EDUCATION INFRASTRUCTURE IN INDIA (1950-86)
(ALLOPATHIC DOCTORS, DENTISTS AND NURSES)

REFERENCE YEARS	MEDICAL COLLEGES		DENTAL COLLEGES	NURSING INSTITUTIONS	
	No.	% Private		B.Sc.	General
1950	28	3.57	4	2	227
1951	30	6.66	4	2	246
1952	30	6.66	5	2	235
1956	46	6.52	7	2	239
1961	68	4.41	12	6	202
1966	89	8.98	14	8	246
1969	95	9.47	15	8	251
1974	105	8.57	15	8	262
1979	107	9.34	17	8	275
1983	111	10.81	25	8	324
1984	116	14.65	25	NA	344
1985	121	15.70	29	NA	374
1986	123	17.07	36	NA	386
1987	125	NA	40	NA	NA

Source : Health Statistics of India, CBHI, GOI relevant years.
Medical Education in India, CBHI, GOI, 1987.
Handbook of Medical Education in India, Association of Indian Universityies, 1987.

Note : NA = Not Available.

TABLE 7 : OUTTURN OF MEDICAL PERSONNEL IN INDIA (1951-52 TO 1987)

REFERENCE YEARS	ALLOPATHS	DENTISTS	POST GRADUATES (Allopaths & Dentists)	NURSES	
				B.Sc.	General
1950	1557	14	88	14	1282
1955	2743	31	110	21	1962
1960	3387	140	397	25	2562
1965	5387	294	791	67	4255
1970	10407	478	1396	101	6257
1976	11962	499	2265	184	5506
1977	13783	449	3694	190	5892
1978	12190*	466	3699	240	6788
1979	13083	515	3562	219	6503
1980	12170*	501	3759	263	7256
1981	12197*	488	3833	214	8144
1982	11992*	541	3940	240	7351
1983	10511	603	4161	315	7750
1984	10469*	662	4909	NA	8533
1985	9177*	567	5121	NA	8956
1986	NA	677	5427	NA	8208
1987	NA	660	5791	NA	NA

Source : Health Information of India, CBHI, GOI, various years.

Notes : * Data on the outturn of allopaths was not received from 2 medical colleges in 1975-76, 1 in 1976-77, 2 in 1977-78, 6 in 1981-82, 7 in 1982-83, 14 in 1983-84, 15 in 1984-85 and 25 in 1985-86. Thus, the data is grossly underrated.

NA = Not Available.

TABLE 8 : COMPARISON OF MIGRATION OF DOCTORS TO ANNUAL OUTTURN OF MBBS STUDENTS (1952-1986)

REFERENCE YEARS	OUTTURN	NO. MIGRATING		NET MIGRATION#	
		No.	%	No.	%
1952-56	12520 (2504)	4050 (810)	(32.35)	3650 (730)	(29.15)
1957-61	16047 (3210)	5175 (1035)	(32.25)	4784 (957)	(29.81)
1962-66	24631 (4927)	5313 (1063)	(21.57)	4813 (963)	(19.54)
1966-69	26494 (6624)	7200 (1800)	(27.17)	6800 (1700)	(25.66)
1970-74	55818 (11164)	15450 (3090)	(27.67)	7950 (1590)	(14.24)
1975-79	63350* (12670)	21300 (4260)	(33.62)	10710 (2142)	(16.91)
1980-83	46870* (11718)	18795 (4699)		9369 (2342)	
1984-86	31148* (10383)	15492 (5164)		7928 (2643)	

Source : IAMR "Brain drain study : Phase I - analysis of ordinary passports issued during 1960-67", p. 23.
CBHI "Health Statistics of India", relevant years.
Rele MR & Bali RS "Study of brain drain of Indian physicians, NIHAE (undated).

Notes : # Net Migration = No. migrating - No. returned.
Figures in parentheses are annual averages.
* Data on the outturn of allopaths was not received from 2 medical colleges in 1975-76, 1 in 1976-77, 2 in 1977-78, 6 in 1981-82, 7 in 1982-83, 14 in 1983-84, 15 in 1984-85 and 25 in 1985-86. Thus, the data is grossly underrated.

TABLE 9 : HEALTH INFRASTRUCTURE IN INDIA : RURAL-URBAN DISTRIBUTION

YEAR	HOSPITALS	DISPENSARIES	PHCS (only Rural)	HOSPITAL BEDS (excl. PHC)	POPULATION PER BED	
					Urban	Rural
1951	2694 (NK)	6587 (79.4)	0	117000 (NK)	-	-
1956	3307 (39.3)	7194 (84.1)	725	145297 (23.0)	487	2272
1961	3054 (32.8)	9406 (53.1)	2565	229634 (15.8)	343	1589
1966	3971 (32.5)	10231 (78.9)	4631	306518 (18.0)	306	1308
1969	4023 (30.7)	10440 (79.1)	4919	328323 (21.0)	310	1295
1974	4014 (25.2)	10200 (71.6)	5283	341064 (11.2)	358	1424
1979	5766 (25.6)	15968 (69.8)	5423	446605 (13.1)	338	1139
1983	6901 (26.4)	17455 (68.6)	5954	486805 (13.5)	369	1109
1988	9381 (31.5)	27495 (47.3)	14145*	585889 (15.8)	363**	1034**

Source : Health Statistics of India, CBHI, GOI, various years.
Statistical Abstract 1984, CSO, GOI, 1985.
Directory of Hospitals in India, CBHI, GOI, 1981.

Notes : Figures in parentheses are percent rural.
NK - Not known
* - Includes Subsidiary Health Centres also.
** - Data relates to the year 1986 when total number of hospital beds was 555264.

TABLE 10 : OWNERSHIP STATUS OF HOSPITALS AND HOSPITAL BEDS

YEAR	HOSPITALS			HOSPITAL BEDS		
	Government	Private	Total	Government	Private	Total
1974	2832	644	3476	211335	57550	268885
	(81.4)	(18.6)	(100)	(78.5)	(21.5)	(100)
1979	3735	2031	5766	331233	115372	446605
	(64.7)	(35.3)	(100)	(74.2)	(25.8)	(100)
1981	3747	2923	6670	334049	132628	466677
	(56.2)	(43.8)	(100)	(71.5)	(28.4)	(100)
1984	3925	3256	7181	362966	137662	500628
	(54.6)	(45.4)	(100)	(72.5)	(27.5)	(100)
1986	4093	3381	7474	394553	141182	533735
	(54.7)	(45.3)	(100)	(73.9)	(26.1)	(100)
1987	4215	3549	7764	411255	144009	555264
	(54.3)	(45.7)	(100)	(74.1)	(25.9)	(100)
1988	4334	5497	9831	410772	175117	585889
	(44.1)	(55.9)	(100)	(70.1)	(29.9)	(100)

Source : Health Information of India, CBHI, GOI, various years.
Directory of Hospitals in India, CBHI, DGHS, GOI, 1981.

Notes : Figures in parentheses denote percentages.
Government figures include ownership by local bodies.
Data on the number and ownership status of hospitals and beds were not reported by 6 states in 1974, 5 in 1979, 1 in 1981, 1984, 1986, 1987 and 1988.
Madhya Pradesh has not reported its data since 1979.

TABLE 11 : RATE OF GROWTH OF HOSPITALS AND HOSPITAL BEDS (BY OWNERSHIP)

YEARS	HOSPITALS		HOSPITAL BEDS	
	Government	Private	Government	Private
1974-79	6.37	43.07	11.35	20.09
1979-84	1.02	12.06	1.92	3.86
1984-88	2.61	17.21	3.29	6.81

Source : Same as Table 10.

Note : Figures are in percentages.

TABLE 12 : OWNERSHIP STATUS OF DISPENSARIES AND DISPENSARY BEDS

YEAR	DISPENSARY			DISPENSARY BEDS		
	Government	Private	Total	Government	Private	Total
1981	13205	2115	15968[a]	26231	1314	277306[b]
	(86.2)	(13.8)	(100)	(95.2)	(4.8)	(100)
1984	14694	6438	21780[a]	30251	5306	35742[b]
	(69.5)	(30.5)	(100)	(85.1)	(14.9)	(100)
1988	13916	13579	27495	21659	2187	23846
	(50.6)	(49.4)	(100)	(90.8)	(9.2)	(100)

Source : Same as Table 10.

Notes : Government figures include ownership by local bodies.

a) Ownership details for 648 dispensaries was not available.

b) Ownership details for 185 dispensary beds was not available.

TABLE 13 : RATE OF GROWTH OF DISPENSARIES AND BEDS (BY OWNERSHIP)

YEARS	DISPENSARY		DISPENSARY BEDS	
	Government	Private	Government	Private
1981-84	0.26	68.13	5.11	101.26
1984-88	-1.32	27.73	-7.11	-14.69

Source : Same as Table 10.

Notes : Government figures include ownership by local bodies.

TABLE 14 : SECTORWISE PRODUCTION OF BULK DRUGS AND FORMULATIONS

(Rs. in Crores)

YEARS	BULK DRUGS			FORMULATION		
	Public Sector	Private Sector	Total	Public Sector	Private Sector	Total
1974-75	33 (35.1)	61 (64.9)	94 (100)	25 (5.0)	475 (95.0)	500 (100)
1977-78	47 (28.7)	117 (71.3)	164 (100)	53 (5.9)	847 (94.1)	900 (100)
1980-81	63 (26.3)	177 (73.8)	240 (100)	80 (6.7)	1120 (93.3)	1200 (100)
1983-84	67 (20.7)	258 (79.4)	325 (100)	-	-	1760*

* Break-up not available.

Source : Dinesh Abrol & Amitava Guha, "Production and Price Controls. The Achilles Heel of National Drug Policy" in "Drug Industry and the Indian People", ed. Dr. Amitsen Gupta, Delhi, Science Forum, 1986, p 140.

TABLE 15 : INDIA'S EXPORTS AND IMPORTS OF MEDICAL EQUIPMENT

(Value in Rs. Lakhs)

YEARS	EXPORTS	% CHANGE	IMPORTS	% CHANGE	BALANCE
1977-78	NK	-	941.20	-	-
1978-79	NK	-	1253.90	+ 33.2	-
1979-80	128.90	-	1547.70	+ 23.4	- 1418.80
1980-81	204.73	+ 58.8	1972.10	+ 27.4	- 1767.37
1981-82	708.89	+ 0.3	2399.00	+ 21.6	- 1690.11
1982-83	688.00	- 2.9	2869.00	+ 19.6	- 2181.00
1983-84	600.00	- 12.7	3268.04	+ 13.9	- 2668.04
1984-85	650.00	+ 8.3	2894.57	+ 11.4	- 2244.57
1985-86	400.00	- 38.5	5857.26	+ 102.4	- 5457.26
1986-87	700.00	+ 75.0	6500.00	+ 10.9	- 5800.00
1987-88	1300.00	+ 85.7	NK	-	-

Source : CEI, Ibid.
CEI, "Handbook of Statistics", 1988.

Notes : NK = Not Known.

TABLE 16 : EXPENDITURE ON MEDICAL EDUCATION IN INDIA (1952-56 TO 1980-83)

(Rs. Million)

REFERENCE YEARS	MEDICAL EDUCATION EXPENDITURE		RECEIPT ON ACCOUNT OF MEDICAL EDUCATION (Fees etc)	% OF EXPEND. RECEIVED AS FEES	MEDICAL EDUCATION EXPENDITURE AS % OF	
	Revenue Revenue A/c.	Capital Capital A/c.			Medical Services Expenditure	Total Health Expenditure
1952-56	66.40 (13.28)	-	19.05 (3.81)	28.7	5.33	3.47
1957-61	190.20 (38.04)	-	23.90 (4.78)	12.6	8.25	5.20
1962-66	466.50 (93.30)	-	44.85 (8.97)	9.6	11.99	7.01
1967-69	486.06 (162.02)	-	40.92 (13.64)	8.4	14.28	7.14
1970-74	1319.95 (263.99)	-	76.60 (15.32)	5.8	16.06	7.25
1975-79	3044.70 (608.94)	356.16 (71.23)	76.95 (15.39)	2.5	12.79	7.21
1980-83	4749.72 (1187.43)	1118.56 (279.64)	76.28 (19.07)	1.7	13.33	6.95

Source : Combined Finance and Revenue Accounts 1951-52 to 1982-83.
Comptroller and Auditor General of India, GOI, various years.
Data has been collected by the Research Team of FRCH.
Duggal, R. (1989).

Notes : Figures are total for period in Rs. million.
Figures in parentheses are annual averages.

TABLE 17 : MEDICAL EDUCATION AND TEACHING HOSPITAL EXPENDITURE IN MAHARASHTRA : 1981 - 89

REFERENCE YEAR	MEDICAL EDUCATION EXPENDITURE (1)	MEDICAL COLLEGES EXPENDITURE (2)	TEACHING HOSPITALS EXPENDITURE (3)	TOTAL MEDICAL EDUCATION EXPENDITURE (1+3)	COLUMN 2 AS PERCENT OF COLUMN 1
1981-82	112.49	97.71	239.03	351.52	86.90
1982-83	122.21	104.63	241.87	364.08	85.60
1983-84	143.70	121.54	272.46	416.16	84.60
1984-85	150.24	124.96	299.83	450.07	83.20
1985-86	162.11	138.82	334.69	496.80	85.60
1986-87	186.68	158.11	399.41	586.09	84.70
1987-88*	203.48	172.39	447.78	651.26	84.70
1988-89@	244.87	192.32	393.67	638.54	78.50

Source : Performance Budget of Department of Medical Education and Drugs, Ministry of Health and Family Welfare, Government of Maharashtra, 1983-84 to 1988-89.

Note : * Revised estimate.
@ Budget estimate.
Expenditure only for 8 Government owned Medical Colleges, excludes 3 municipal owned colleges of Bombay and 1 private college.

APPENDIX II

CORPORATISATION OF HEALTH CARE

The U.S.A. is a good illustration of corporate interest in health care delivery. This phenomenon has been termed as 'medical-industrial complex' (Relman, 1984). Expansion of private health care, especially corporate has been very marked. The great boom in the 1960s in the health industries was largely a product of government subsidisation of this market through direct payments, tax exemptions, sponsorship etc. or indirectly through provision of trained humanpower, hospital construction and the like. The biggest government subsidy came in 1966, in the form of Medicare and Medicaid. By 1969, federal, state and local governments directly picked up more than a third of the tab for a steadily increasing government guaranteed market. Unfortunately, only a small part of the money being pumped in by the government has been spent to improve the health care and a majority consist of profits to stockholders and towards financing the companies' expansion into other spheres of health.

Modern technological advances have facilitated the increasing profits of these bodies. In the U.S.A., between 1980-84, corporate revenues in health care grew from $ 25 billion to $ 118 billion, along with increased monopolisation through mergers and takeovers. In the same period, of the 37 largest health and welfare corporations only two lost money, whereas 13 more than doubled their revenues (Stoesz, 1986).

This trend is true of most capitalist nations and is fast emerging in the poorer nations too. In India, health has been only recently discovered as a marketable, profitable commodity on a large, corporate, geographic level. Large business houses with corporate interests were quick to realise that health could also be transformed into an industry with desirable features - a large and available market of illnesses, access to a ready, qualified and trained labour and the new miraculous, state-of-art medical technology. With these recommending characteristics, the health market soon attracted corporate suppliers who established their branches in many pockets of the country, thus gaining a monopoly over a fast burgeoning range of goods and services for which technological innovations created increasing demands. Thus, these medical establishments not only generated newer health needs, but also, determined how these were to be met through such establishments.

The large business houses that run their own regular businesses have now diversified into health. In a span of less than ten years, we have seen a number of corporate groups such as Apollo Hospitals Enterprises Ltd., Escorts Heart Institute, Medinova (which is a division of Standard Medical Leasing of the Hyderabad based Standard Organics Group), Surlux Diagnostic Centres etc.

In a span of two years (1984-86), over 60 diagnostic centres have entered the market with an investment of over Rs. 200 crores in sophisticated equipment. Today, Bombay has 13 body scanners, Delhi has 11, Madras 8, Calcutta 3, Hyderabad 2, Pune 3 and Ahmedabad 3. There are around 100 CT scanners in the whole of India. **Medinova Diagnostic** Centre had plans to open major and satellite units in atleast ten cities in South India, at an investment of Rs. 15 crores by mid 1988. A new entrant into this field is the **Surlux Health Centres Ltd.**, which had offered shares for public subscription. Surlux Diagnostic Ltd. has already set up five centres equipped with the latest medical technologies at Agra, Baroda, Pune and two in Bombay. The company had declared a dividend of 19% for 1988. It had been opened to the public in 1986 and the same was oversubscribed more than 16 times and its share was being quoted at Rs. 12/- on the Bombay stock exchange. The new project of the Surlux Company is its Health Centres Ltd. which has recently been opened for public subscription. The company proposes to set up 'health centres' with branches having CT scan facilities at Bombay, Thane, Nasik and Aurangabad. Six other centres on similar lines are proposed to be set up by 1990. The capital outlay of this project is Rs. 29.7 crores and is being financed by other loan arrangements. The cost of the medical equipment alone is estimated at Rs. 26 crores. The company also plans to have a tie-up arrangement with various companies for providing medical facilities to their employees. The management has already projected a turnover of Rs. 10.9 crores with net profits of Rs. 2.6 crores for the first year alone.

The United Group considered to have pioneered the concept of diagnostic centre in India, was one of the first to import and set up a brain CT scanner in Bombay in 1980, at total investment of Rs. 60 lakhs. This group did over 14 brain scans per day at rates of over Rs. 1000/- each. Within two years, the investment paid off and profits began pouring in. Currently, the group has 46 branches in different parts of the country and plan to set up another 15 centres in the next few years, this time in small towns. The United Group owns over 32 body scanners and 14 brain scanners in the country. There are around 3-5 scans done per day even at branches in small places like Behrampur and Jabalpur (Indian Express, May 18, 1989).

Apollo Hospitals Enterprises Ltd (AHEL) : India's first ever corporate hospital was the Rs. 15 crore project of the AHEL which set up its first hospital in Madras in 1983. The AH was established as a super speciality corporate hospital which allowed public participation in the hospital's equity and share its profits with shareholders.

The first few years of operation (1984-86) saw the hospital suffer a net loss of Rs. 1.51 crores (Rs. 36 lakhs in 1985 and Rs. 65 lakhs in 1986) on a total turnover of Rs. 12.1 crores (Rs. 5.72 crores in 1985 and Rs. 6.38 crores in 1986). But in the calendar years ending 1987 and 1988, the AHEL recovered its

setbacks suffered due to losses in the previous years. AHEL recorded a healthy turnover of Rs. 8.34 crores in 1987 and Rs. 11.48 crores in 1988 and a net profit of Rs. 1.02 crores (1987) and Rs. 1.66 crores in 1988.

The success story of the Madras based AHEL is now being repeated in the other parts of the country. Similar projects have been already started in Hyderabad with an initial investment of Rs. 12 million and are being planned to be set up in Delhi, Bangalore, Bombay, Ahmedabad, Calcutta and Guwahati.

In its start, AHEL had received financial support from State institutional financial bodies. Once convinced that the hospital-cum-hotel project was financially feasible, the Indian Overseas Bank agreed to provide term loans to the tune of Rs. 2.25 crores through a consortium of leading banks such as the Andhra Bank, Canara Bank, Indian Bank and the Syndicate Bank, each offering a loan of Rs. 45 lakhs. Further, armed with RBI and other Government clearances, a deferred payment of 8 million Swiss francs, i.e. Rs. 3.75 crores in Indian equivalent, was procured for the purchase of medical equipments. The third group of contributors were the NRIs, particularly the Indian doctors overseas who contributed an investment of Rs. 70 lakhs to this project (Business India, 1983).

Apollo has entered into a new venture in its project at Delhi, this time in collaboration with the Delhi administration. This is a bigger step towards privatisation with the state openly strengthening the private sector. The Delhi Administration and the Apollo group have together promoted a joint sector company- "Indraprashtha Medical Corporation Ltd", to establish a 600-bedded super speciality. The hospital building costing Rs. 12-15 crores has been given on lease by the state for a token payment of one rupee per year to this company. As a favour to this allowance, the company will provide free, medical, diagnostic and other facilities to 200 in-patients and 40% of the out-patients. The cost of the project is tentatively estimated to be Rs. 30 crores. But it is well expected to shoot up by the time the project is completed. A third of the cost will be raised through equity capital and the remaining two-thirds through loans from govt. financial institutions. Of the equity capital, the Delhi administration will buy 26% of the shares and the Apollo group another 25%. The balance of 49% will be open to the general public, including NRIs. While the Delhi administration will have its nominees on the board of directors, the day to day management of the hospital will rest entirely with the promoter.

It is very obvious that the AHEL could not have consolidated its position and achieved its estimated profits without the support of the state or its other institutions, viz. financial bodies.

APPENDIX III

RESEARCH AREAS

While studying literature on the private sector and privatisation in the field of health care, we could identify many areas which need further systematic research. Some gaps in our knowledge of the actual situation in the field are such that we often got a feeling that without undertaking further research on those areas, it is very difficult to provide a balanced picture which could be of some us to the policy makers. Therefore, we have made an attempt to identify areas which are of academic interest as well as of interest in terms of formulating future policies.

A. Historical Research in Health Care Service : Very little is known about how the health care was provided to common people in earlier times. An attempt needs to be made in a systematic way to trace the social and medical care history from the ancient to modern times in India. Before that, however, for the ancient and medieval periods, a preliminary survey of the existing historical material should be undertaken to assess the availability of material on health care. We are quite confident that for modern period, especially the British period, there is enough documented material available to undertake several studies on the health care services. Certain important issues to be explored are :

(1) The state patronage for medical schools, hospitals etc. (2) The state patronage to individual practitioners (3) The relationship between the "elite" and "folk" medicine (4) Interests of religious institutions in provision of health care (5) Codes of ethics in various Indian systems (6) Organisations of physicians in the ancient and medieval times : The causes of their weakness or absence (7) Women in Indian folk medicine. The role of dais in women's health (8) The British rule and its effect on the state patronage to Indian medicine (9) The actions and non-actions of the state during British rule that affected Indian medicine. (10) The Public health in the British times (11) Causes of decline of the Indian medicine.

B. State Intervention in Health Care : The Indian state since independence has been very active in health care. Its intervention in creating public sector health care is studied by many, but its intervention in developing private sector heath care is scantily paid attention in the research. Relevant issues are : (1) State subsidies to the private health care sector (2) The state, medical education and the private care sector (3) State funding of private medical colleges (4) The public financial institutions, bank etc. and their role in financing investment in health care services (5) Causes of underdevelopment of public health care sector (6) The nature of welfare functions of Indian State.

C. Private Health Care Sector : This area of research is almost completely neglected. The amount of research input required is going to be enormous and would need long term systematic planning. There are going to be many methodological problems in undertaking such studies and above all, there will be practical problems in collecting data. We would require smaller studies to understand its functioning as well as bigger studies to assess its volume and the role. Some relevant areas are :

(1) Study of investment in private sector health care (2) Study of utilisation of private health care sector (3) Expenditure studies (4) new medical technologies and their diffusion (5) Who utilizes private health care and why? (6) The organiation of private health care sector (7) The nature of medical practice (8) Supplier induced demand (9) The knowledge of national disease control programmes and knowledge about the rational line of treatment for common diseases (10) Sources of medical information (11) Income of private doctors (12) Cost of health care in private sector etc.

D. Public and Private Health Care Sectors : Comparison : Social cost benefit analysis of the public and private sectors health care provision is an area not given adequate attention. Financial efficiency, technical efficiency and social efficiency of public and private health care institutions need to be studied.

E. Methods of Health Care Provision and Financing : Various methods of health care provision and financing are tried out in the private as well as the public sectors. They are : (1) Contracting out method: Private sector has participated in building constructions for PHCs, hospitals, dispensaries. Their quality and usefulness needs to be studied. Certain hospital functions, like laundry etc. are contracted out. There has been reports about parts of government hospitals contracted to the private sector. All these should be studied to understand their usefulness and efficiency. (2) Doctors retained on capitation fees : In the ESIS, and some public sector enterprises private doctors are retained on capitation fees. (3) Study of private medical colleges charging high capitation fees. Study of students and their education and training in these colleges. (4) Study of non-allopathic private medical colleges, etc.

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